



Baylor College of Medicine Children's Foundation Malawi

Tingathe Program

Fiscal Year 19 Annual Progress Report

October 1, 2018 – September 30, 2019



A Site Supervisor conducts a morning health talk at Area 25 Health Center in Lilongwe, Malawi

Tingathe program

Technical Support to PEPFAR Programs in the Southern Africa Region (TSP) project

Cooperative Agreement: AID-674-A-16-00003

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Contents

| | |
|--|----|
| List of Figures | 4 |
| Acronyms..... | 5 |
| Executive Summary | 7 |
| Tingathe FY19 Strategic Objectives | 8 |
| Program Summary..... | 9 |
| Program Results | 9 |
| Active Case Finding..... | 9 |
| SO 1 - PITC: Implementation progress | 10 |
| SO 2 - ICT: Implementation progress | 14 |
| SO 3a - Outreach for males and youth: Implementation progress | 18 |
| SO 3b - Outreach for KPs: Implementation progress | 19 |
| Active Case Finding challenges and responses for FY19 | 19 |
| Active Case Finding activities in the next quarter | 20 |
| Active Linkage and Retention | 21 |
| SO 4 - Linkage: Implementation progress | 22 |
| SO 5 - ART initiation: Implementation progress..... | 23 |
| SO 6 - Retention in care: Implementation progress..... | 24 |
| Active Linkage and Retention challenges and responses..... | 25 |
| Active Linkage and Retention activities in the next quarter | 26 |
| SO 6 a - Adolescent care: Implementation progress..... | 27 |
| Adolescent care challenges and responses..... | 28 |
| Adolescent care activities in the next quarter | 28 |
| SO 6 b - Differentiated models of care: Implementation progress..... | 28 |
| DSD related activities in the next quarter | 30 |
| Viral Suppression | 31 |
| SO 7 and 8 - Viral load testing coverage and cascade management: Implementation progress | 31 |
| Viral Suppression challenges and responses..... | 34 |
| Viral Suppression activities in the next quarter | 35 |
| SO 9 - Strengthen TB management: Implementation progress | 36 |
| Strengthen TB management: challenges and responses | 37 |
| TB management: challenges and responses | 37 |
| Strengthen TB management: Activities in the next quarter | 38 |
| TB management: Activities in the next quarter | 38 |

| | |
|---|----|
| Health Systems Strengthening..... | 38 |
| SO 12 - Quality assurance/quality improvement: Implementation progress..... | 38 |
| Quality Improvement Projects..... | 39 |
| HSS challenges and responses | 39 |
| HSS activities in the next quarter | 41 |
| Prevention | 42 |
| SO GBV: Implementation progress | 42 |
| GBV challenges and responses | 43 |
| GBV activities in the next quarter | 43 |
| Cervical Cancer: Implementation progress | 46 |
| Cervical Cancer challenges and responses..... | 47 |
| Cervical Cancer activities in the next quarter | 47 |
| Environmental Mitigation and Monitoring..... | 47 |
| Monitoring and Evaluation..... | 48 |
| Operational Research | 49 |
| Ongoing research projects | 49 |
| Articles published in FY19; | 50 |
| Management and Operations | 53 |
| Program Operations | 53 |
| Human Resources..... | 53 |
| Financial Management | 0 |
| Success Story..... | 1 |
| Appendices..... | 3 |
| Appendix 1: Tingathe Custom Indicators (Non-PEPFAR) | 3 |

List of Figures

| | |
|---|----|
| Figure 1: Tingathe PITC coverage and prevalence October 2018 to September 2019(FY 19) | 10 |
| Figure 2: New HIV-Positive cases in Machinga and Mangochi districts from FY19, by age and sex | 11 |
| Figure 3: Number of HIV Self-Test kits distributed by district and month | 12 |
| Figure 4: HIV Self-Test Kits (STK) intended end users in FY 19..... | 12 |
| Figure 5: HIV testing coverage in maternity, FY19..... | 13 |
| Figure 6: EID coverage by district FY19..... | 14 |
| Figure 7: HIV tests by ICT and Yield from 7 district in FY 19..... | 15 |
| Figure 8: Proportion of new HIV positive cases from ICT in FY19..... | 15 |
| Figure 9: Proportion of contacts receiving active vs. passive methods, Machinga and Mangochi, Q2 -Q4 FY19..... | 16 |
| Figure 10: VAPN tested by strategy type in Q4 FY19 | 16 |
| Figure 11: Index Case testing cascade from new positive clients in HTS & ART Clinics Q4 FY19 –Machinga and Mangochi | 17 |
| Figure 12: Contact return and yield by index type in Machinga and Mangochi districts, Q4 FY19 | 17 |
| Figure 13: ART linkage per district, FY19 | 22 |
| Figure 14: Linkage by age and sex, FY19 | 23 |
| Figure 15: Cohort transitioned to TLD FY19..... | 24 |
| Figure 16: Number of Teen Clubs in FY19..... | 27 |
| Figure 17: Tingathe FY19 routine VL cascade (data source: LIMS) | 32 |
| Figure 18: VL Coverage by age, sex, district for clients <15years..... | 32 |
| Figure 19: VL Coverage by age, sex, district for clients >15years..... | 32 |
| Figure 20: Routine VL suppression (<1000c/ml) by sex and age groups | 33 |
| Figure 21: Tingathe HIV testing coverage in TB patents FY19 | 37 |
| Figure 22: GBV by type, Machinga district - FY19..... | 42 |
| Figure 23: Number of GBV survivors reached with minimum package of services, Machinga District in FY19 | 42 |
| Figure 24: Tingathe Cervical Cancer Cascade, FY19 | 44 |
| Figure 25: Cervical Cancer Cascade, disaggregated data -Q4 | 44 |
| Figure 26: Number of women living with HIV screened for cervical cancer – FY19..... | 45 |
| Figure 27: Site level achievement of cervical cancer screening -FY19..... | 45 |

Acronyms

| | |
|---------|---|
| AIDS | Acquired Immune Deficiency Syndrome |
| ALHIV | Adolescents Living with HIV |
| ANC | Ante-Natal Care |
| ART | Anti-Retroviral Therapy |
| ARV | Anti-Retroviral |
| BCM-CFM | Baylor College of Medicine Children's Foundation Malawi |
| CHAM | Christian Health Association of Malawi |
| CDC | Centers for Disease Control and Prevention |
| CHPO | Community and HTS Program Officer |
| CHW | Community Health Worker |
| CO | Clinical Officer |
| COE | Clinical Centre of Excellence |
| CPD | Continuing Professional Development |
| CQI | Continuous Quality Improvement |
| DHA | Department of HIV/AIDS |
| DHMT | District Health Management Team |
| DHO | District Health Office/Officer |
| DQA | Data Quality Assessment |
| DSD | Differentiated HIV Service Delivery |
| EID | Early-Infant diagnosis FP |
| EMRS | Electronic Medical Record System |
| FP | Family Planning |
| FRS | Family Referral Slip |
| FSW | Female Sex Worker |
| FY | Fiscal Year |
| GBV | Gender Based Violence |
| GoM | Government of Malawi |
| HCW | Health Care Worker |
| HDA | HIV Diagnostic Assistants |
| HF | Health Facility |
| HTS | HIV Testing Services |
| HIS | Health Information Systems |
| HIV | Human Immunodeficiency Virus |
| HMIS | Health Management Information System |
| HSA | Health Surveillance Assistant |
| HTC | HIV Testing and Counseling |
| IAC | Intensive Adherence Counseling |
| ICAC | Intensified Care ART Clinic |
| ICT | Index Case Testing |
| IPT | Isoniazid Preventive Therapy |
| KP | Key Population |

| | |
|-------------|---|
| LIMS | Laboratory Information Management System |
| LPV/r | Lopinavir/ritonavir |
| M&E | Monitoring and Evaluation |
| MIP | Mother-Infant Pair |
| MMS | Multi-Month Scripting |
| MOH | Ministry of Health |
| MOU | Memorandum of Understanding |
| NRU | Nutritional Rehabilitation Unit |
| OPD | Out-Patient Department |
| OR | Operational Research |
| OTP | Outpatient Therapeutic Program |
| PEPFAR | President's Emergency Plan for AIDS Relief |
| PITC | Provider Initiated Testing and Counseling |
| PLHIV | People Living with HIV/AIDS |
| PMTCT | Prevention of Mother-To-Child HIV transmission |
| POC | Point of Care |
| Q1,Q2,Q3,Q4 | Quarter 1, Quarter 2, Quarter 3, Quarter 4, |
| QI | Quality Improvement |
| SFP | Supplemental Feeding Program |
| SIMS | Site Improvement through Monitoring System |
| SO | Strategic Objective |
| SOP | Standard Operating Procedures |
| SS | Site Supervisor |
| STI | Sexually Transmitted Infection |
| TB | Tuberculosis |
| TC | Teen Club |
| TCT | Targeted Community Testing |
| TSP | Technical Support to PEPFAR Programs in Southern Africa |
| TWG | Technical working group |
| USAID | U.S. Agency for International Development |
| VAPN | Voluntary Assisted Partner Notification |
| VL | Viral Load |
| WHO | World Health Organization |
| YFHS | Youth Friendly Health Services |
| YS | Youth Supporter |

Executive Summary

KEY ACHIEVEMENTS FY19

1,043,912
Clients tested for HIV

30,457
Clients tested HIV positive

2.9%
Yield

29,204
Newly initiated on ART

96%
Linkage

198,269 Clients currently on ART

89%
Viral Load Suppression

24, 093
Adolescent visits to Teen Clubs

59
Teen club sites

764
Survivors provided minimum package of GBV service

10,763
HIV positive women screened for cervical cancer to date, 113% of annual target

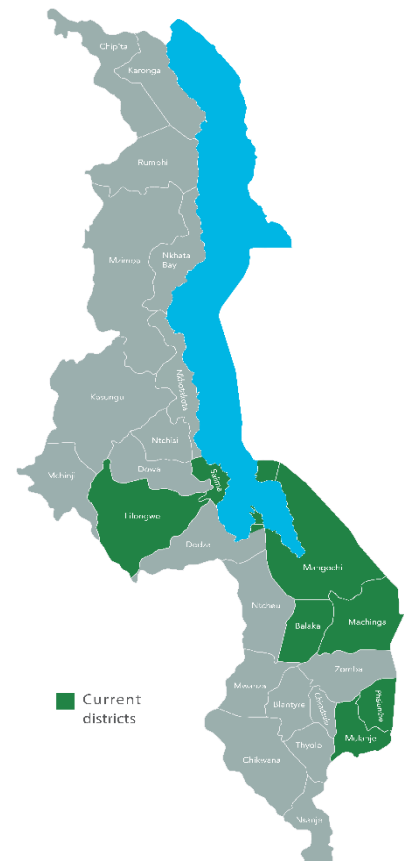
120
Health facilities supported in 7 Districts

The Technical Support for PEPFAR Programs in Southern Africa (TSP) project is a five-year project (2016-2021) implemented by Baylor Tingathe Program under a cooperative agreement between Baylor College of Medicine Children’s Foundation Malawi (Baylor-Malawi) and the USAID Regional HIV and AIDS Program (RHAP).

Baylor Tingathe program is supporting the Malawi Ministry of Health to achieve HIV epidemic control by reaching the UNAIDS 95-95-95 targets by 2020 through care and treatment, prevention and health systems strengthening approaches. Tingathe supports 120 health facilities in seven districts: Mangochi, Machinga, Mulanje, Balaka, Salima, Phalombe and Lilongwe. Tingathe’s work is guided by five key approaches: index case testing, HIV self-testing, retention and adherence, viral load scale up and TB/HIV case identification and management. In addition, the program ensures that eligible clients are initiated or transitioned to Dolutegravir based ARV regimens while those stable on treatment are offered multi-month drug scripting.

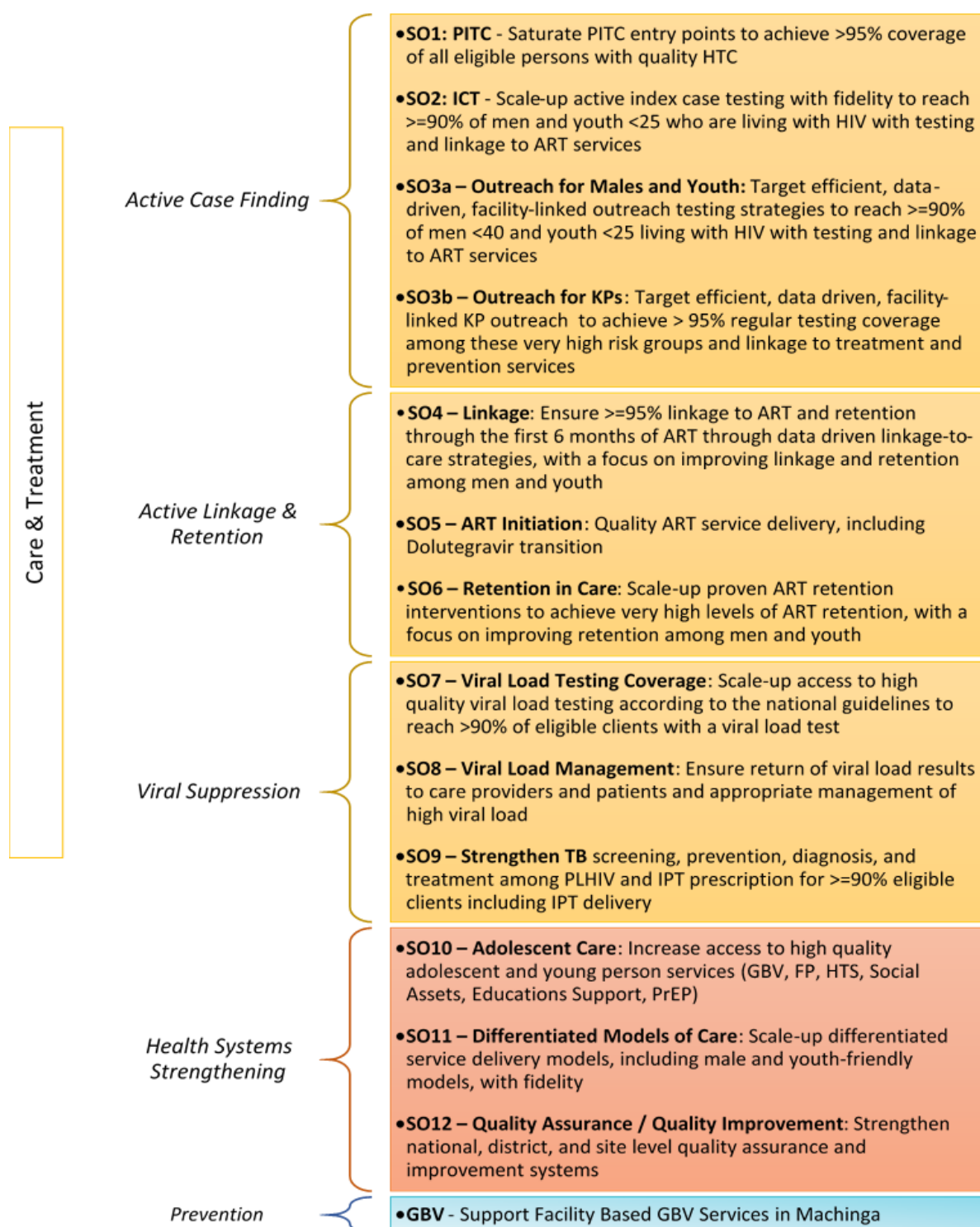
In FY19, Baylor Tingathe program was very instrumental in the delivery of HIV care and treatment services in Malawi with focus on HIV care and treatment policy development, capacity building, and service delivery. The program participated at various national level forums in collaboration with MOH, USAID and other partners, including national technical working groups, task forces, and strategic development teams.

This report describes project achievements of fiscal year (FY) 19; October 1, 2018 to September 30, 2019.



Tingathe FY19 Strategic Objectives

The program is guided by the following strategic objectives;



Program Summary

Table 1: Tingathe quarterly achievement by indicator

| Indicator | Annual Target | Quarter one results | Quarter two results | Quarter three results | Quarter four results | % of Annual target achieved |
|----------------------------|---------------|---------------------|---------------------|-----------------------|----------------------|-----------------------------|
| HTS_TST | 621,926 | 255,041 | 289,953 | 246,691 | 252,227 | 168% |
| HTS_TST_POS | 32,117 | 7,673 | 8,456 | 7,338 | 6,990 | 95% |
| TX_NEW | 34,284 | 7,146 | 7,973 | 7,088 | 6,995 | 85% |
| TX_CURR (Annual target) | 239,096 | 198,084 | 199,036 | 202,953 | 198,269 | 83% |
| PMTCT_STAT | 135,393 | 39,915 | 44,411 | 42,197 | 44,207 | 126% |
| PMTCT_ART | 11,317 | 3,370 | 3,524 | 3,559 | 3,430 | 123% |
| PMTCT_EID | 11,322 | 5,771 | 6,133 | 5,713 | 5,553 | 205% |
| TB_STAT | 2,484 | 622 | 763 | 955 | 732 | 124% |
| TB_ART | 1,207 | 296 | 366 | 316 | 312 | 107% |
| TX_PVLS, D | 149,004 | 24,705* | 113,705 | 130,051 | 131,306 | 88% |
| CXCA_SCRN | 9,545 | 720 | 2,515 | 2,958 | 4,570 | 113% |
| GEND_GBV | 551 | 764 | | | | 139% |
| PMTCT_FO | n/a | 13,556 | | | | 97% |

* Note for Q1 2019, TX_PVLS represented only one quarter of results, whereas Q2- Q4 data represent annual (four quarters) achievement as to reflect MER guidance.

Tingathe performed exceptionally well in FY 19, achieving more than 80% of the target in all indicators and surpassing target for 9 out of 13 indicators. The program results section below highlights performance progress and explains activities implemented to achieve targets.

Program Results

Active Case Finding

| SO # | SO | Explanation |
|------|------------------------------|---|
| 1 | PITC | Saturate PITC entry points to achieve >95% coverage of all eligible persons with quality HTC |
| 2 | ICT | Scale-up active index case testing with fidelity to reach >=90% of men and youth <25 who are living with HIV with testing and linkage to ART services |
| 3a | Outreach for males and youth | Target efficient, data-driven, facility-linked outreach testing strategies to reach >=90% of men <40 and youth <25 living with HIV with testing and linkage to ART services |
| 3b | Outreach for KPs | Target efficient, data driven, facility-linked KP outreach to achieve > 95% regular testing coverage among these very high-risk groups and linkage to treatment and prevention services |

Tingathe program identified 30,457 newly diagnosed HIV-positive clients as a result of 1,043,912 tests done in FY19. The program implemented optimized testing approaches aimed at reducing the overall number of tests done, but with increased HIV positivity yield resulting in high achievement of 3% and a high performance towards the annual target for HIV positive cases identified at 96%. Tingathe continued to implement multiple HIV case finding approaches including provider-initiated testing and counselling (PITC), self-testing, index case testing (ICT) and targeted community testing (TCT) in all supported facilities. HIV Diagnostic Assistants (HDAs) and Community Health Workers (CHWs) played a key role in each of the approaches by actively screening clients and providing testing and counselling services.

SO 1 - PITC: Implementation progress

PITC contributed 78% of the total HIV tests done in FY 19 with an average coverage of 95% in all entry points. As illustrated in the figure below, PITC coverage was high at all service delivery points, with high prevalence recorded at adult female and pediatric wards (19% for both) while Nutrition Rehabilitation Unit (NRU) and Outpatient Therapeutic Program (OTP) recorded the lowest prevalence at 4%, consistent with the fact that the majority of patients accessing these services are children.

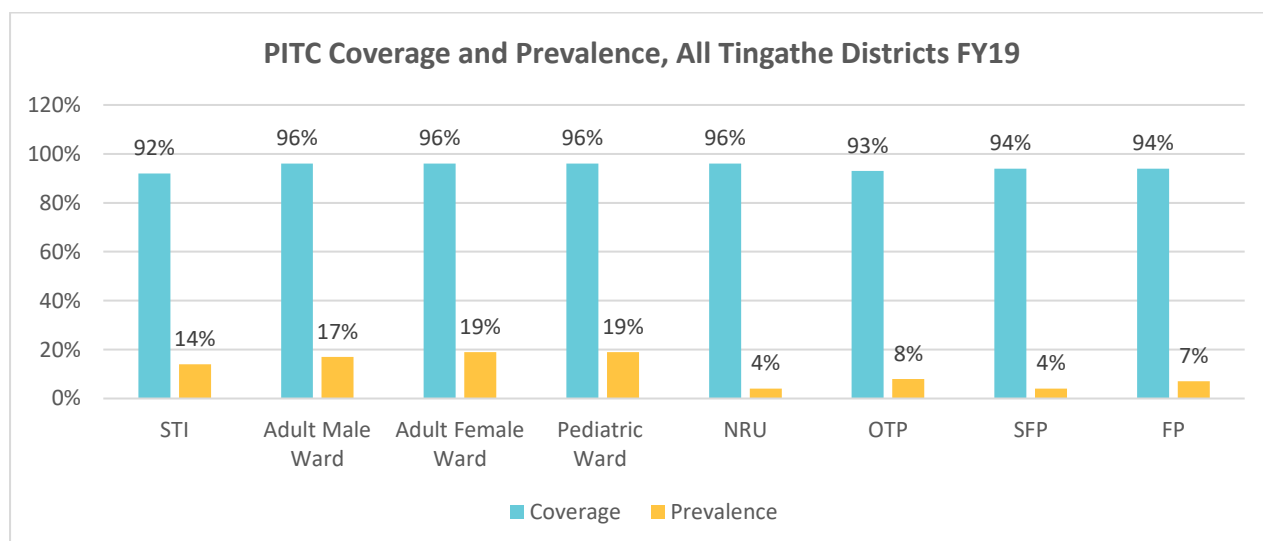


Figure 1: Tingathe PITC coverage and prevalence October 2018 to September 2019 (FY 19)

In FY19 Tingathe transitioned to more targeted testing, through emphasis on scale-up of ICT, expansion of HIV Self-test (HIVST) services, and revision of the outpatient department (OPD) screening approach by changing eligibility criteria from 3 to 12 months since previous HIV test. Resultantly, the number of tests done reduced by 8.5% (498,918 from 544,994) in quarters 3 and 4 compared to quarters 1 and 2. This corresponded with an associated decrease in the number of new HIV cases identified within these periods. Despite this, the program yield was sustained at 3.0% leading to an annual achievement of 95% of new case identification target.

HTS outcomes in Machinga and Mangochi districts in Q4 show the highest yield (5.6%) was achieved in men between 25 – 49 years. Despite multi-faceted program efforts to reach men for HIV testing in OPD, the proportion of men tested remained low across the quarters in FY19 as illustrated in the figure below.

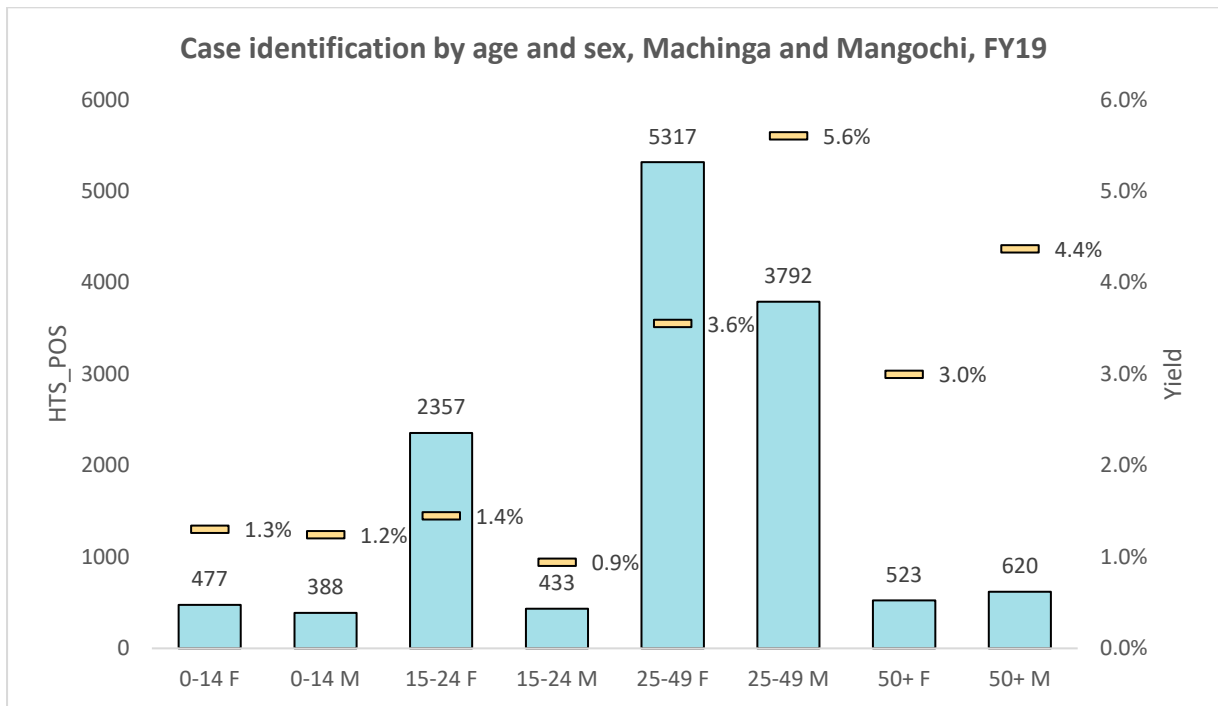


Figure 2: New HIV-Positive cases in Machinga and Mangochi districts from FY19, by age and sex

To close gaps and reduce missed opportunities in PITC, Tingathe implemented several interventions in all supported sites to increase HIV case identification. OPD testing was implemented in all supported sites, and every morning, Community Health Workers (CHW) and HIV Diagnostic Assistants (HDA) provided tailored health education on the importance of HIV testing to clients at OPD waiting areas. They screened health passbooks and offered HIV testing to all clients who had never tested, those who had a negative HIV test result more than a year ago and all men ≥ 25 years; except those with a known HIV positive status. Tingathe changed OPD screening criteria in quarter two from 3 to 12 months since previous HIV test to reduce unnecessary testing. To further optimize HIV testing in the OPD setting, Tingathe supported the field test of a pediatric PITC screening tool for use in outpatient settings championed by CHAI and MOH. The program continued to provide early morning testing (Monday to Friday from 6-7am) and weekend testing (Saturday from 8am-12noon) to increase access to HTS for populations that were unavailable for testing during the conventional timings.

In FY19, HIV self-testing (HIVST) was rolled out to 4 districts, with a specific focus on targeting men and youth. In Mangochi and Machinga HIVST activities begun in Q2, and Q4 in Balaka and Salima districts. Tingathe trained 342 CHWs to be HIV self-test-kit distributors; these were drawn from all seven districts of program implementation. Distribution of HIV self-test-kits in Mulanje, Phalombe and Lilongwe will begin in FY20.

In FY19, a total of 18,113 HIV self-test kits were distributed in Machinga Mangochi, Balaka and Salima districts. The graph below shows number of HIVST kits distributed per district by quarter.

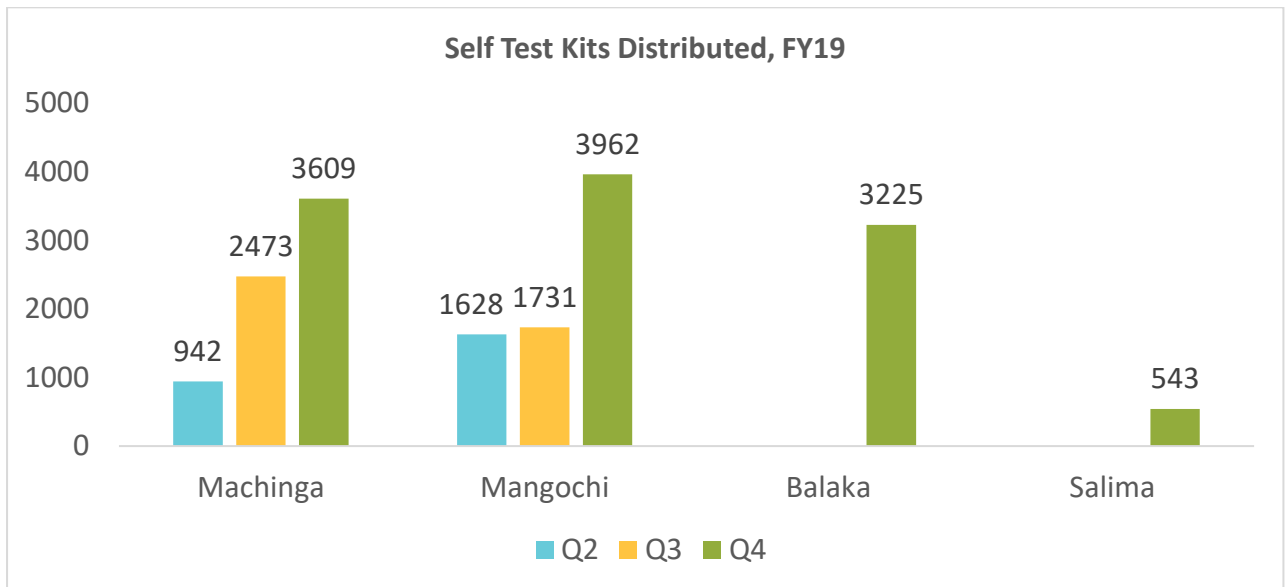


Figure 3: Number of HIV Self-Test kits distributed by district and month

During the reporting period, 61% of the HIVST kits were distributed for use by sexual partners, 23% were intended for self-use and 16% for other contacts. Distribution of self-test kits at antenatal clinic targeted sexual partners, resulting in the high proportion of self-test kits distributed for partners.

Intended end user, Tingathe Program FY19

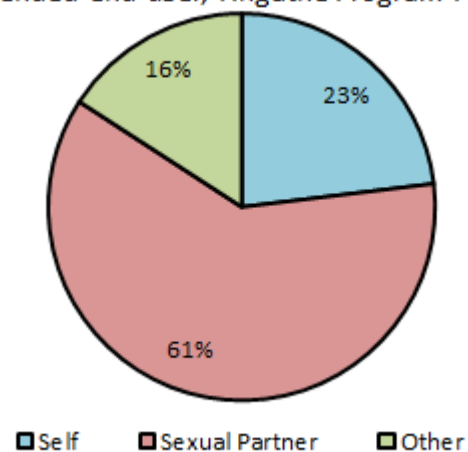


Figure 4: HIV Self-Test Kits (STK) intended end users in FY 19

With two additional districts distributing, there was a 170% overall increase in kits distributed in Q4 at 11,339 from 4,451 in Q3. Mangochi and Machinga districts achieved a 129% and 46% increase respectively in number of HIV self- test kits distributed from in Q4. This success is attributed to scale up of HIVST services, clear communication of site level targets and ongoing guidance to clearly define which clients should be prioritized to receive a self-test kit.

Distribution of HIV self-test kits focused on ANC clients without partners present, Sexually Transmitted Infections (STI) clients, and ICT clients. Clients issued with HIVST kits were instructed to visit the facility for a confirmatory rapid HIV test after receiving an HIV-positive self-test result. Tingathe continues to train HTS providers to screen clients accessing HTS services to establish their use of HIV self-testing, and document this in the HTS register, to monitor clients returning to facilities for confirmatory tests after a positive result from HIV self-testing. In Mangochi district, females took self-test-kits for their male partners twice as often as males for their female partners and males were twice as likely to request one for own use. Attrition of trained self-testing providers in Mangochi district left fewer trained providers to distribute kits. Tingathe trained more HIVST distributors in Q4 to address this challenge.

Tingathe continues to provide HIV testing for pregnant women at ANC clinics and maternity wards. In FY19, HIV testing coverage in maternity wards was >94% in all supported districts. To maintain high coverage, CHWs and HDAs screened health passport books of women in maternity ward and offered a test to women with a previous negative test result and those never tested. Tingathe team worked hand in hand with maternity staff to ensure that all women discharged from maternity ward have their HIV status ascertained. Clients admitted and discharged during the weekend were missed in most facilities; to address this, a flexible rotation schedule was developed for Tingathe site staff to allow some to cover weekends at busy facilities.

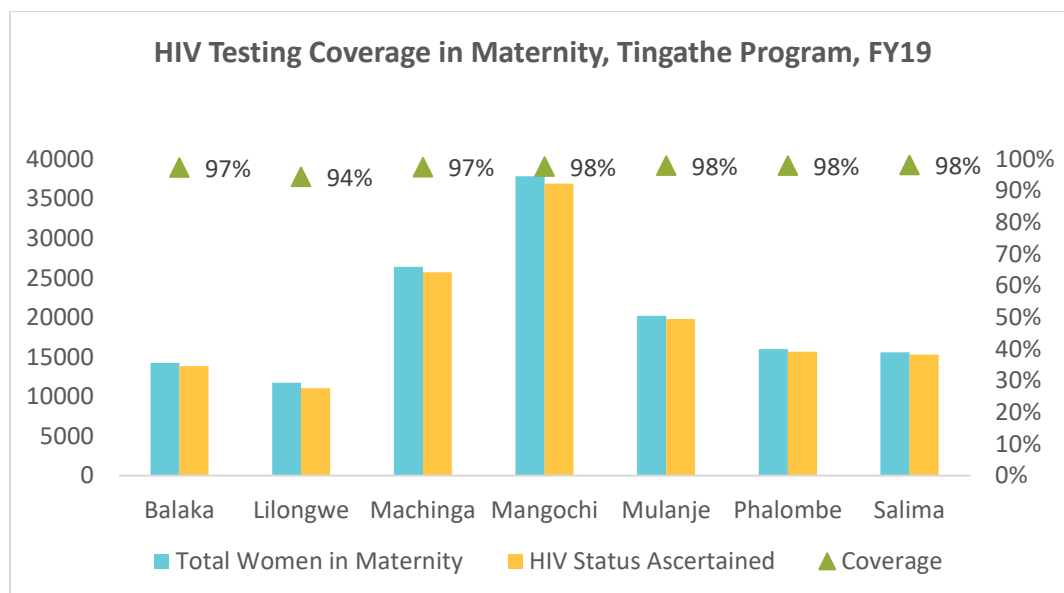


Figure 5: HIV testing coverage in maternity, FY19

Early Infant Diagnosis (EID) coverage at 2 months was above 80% in Lilongwe, Mulanje and Phalombe districts, while 12 months coverage was also above 80% in Balaka, Mulanje and Phalombe. The program continues to support mother infant pair clinics (MIP) as standalone in 68 sites and in integration with Antiretroviral Therapy (ART) clinics and continues to advocate with MOH for establishments of the same in sites where this is not practiced. Several challenges affected EID coverage in the annual period: documentation of results on pink cards was a challenge in some sites - EID test results for some infants were printed and filed with the pink infant mastercard but not documented on the card itself. In addition, lack of coordination between mother's appointment date and the date the child requires an HIV test resulted in delays in 12- and 24-month tests for some infants. To address these challenges, the program reoriented Coordinators and CHPOs on the pink card EID audit process to ensure that they are more closely following EID and continually developing interventions to improve coverage in supported sites. Mentors encouraged providers to coordinate mother-infant visits around the timing of infant testing and site supervisors to ensure infant appointments are entered in the appointment register to facilitate follow up. The figure below illustrates FY19 EID coverage by district.

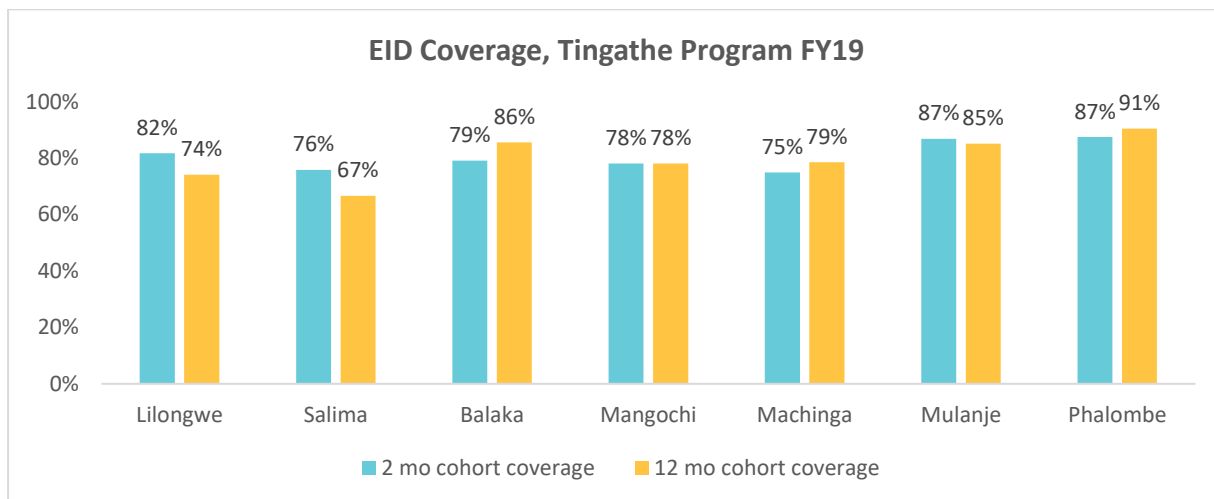


Figure 6: EID coverage by district FY19

Tingathe program continued to use coding in the HIV testing and counselling (HTC) register in Machinga and Mangochi supported sites to identify strategies with the highest yield and to help sites focus on high-yield strategies to identify more HIV-positive cases. Testing data is collected from all sites on a monthly basis, and performance feedback is given to sites through feedback loop meetings. OPD continued to contribute the largest percentage of new HIV-positive cases, with OTH (including PITC) and antenatal care (ANC) service delivery points follow in

SO 2 - ICT: Implementation progress

Index case testing (ICT) was implemented as an efficient strategy for increased HIV case identification throughout the annual period. Tingathe supported delivery of ICT services at all 120 facilities, with support for Voluntary Assisted Partner Notification (VAPN) services in Mangochi, Machinga, and Mulanje districts. In Mulanje, VAPN services commenced in Q4 following the training of service providers. The continued scale up of assisted partner notification methods to complement passive referral systems contributed to increasing numbers of new clients identified through this strategy.

With an overall yield of 19%, ICT was the highest yield HIV case identification strategy in FY 19 with a total of 35,703 clients tested through index case testing of which 6,934 were newly identified HIV positive. The seven districts recorded high yield ranging from 10% in Lilongwe to 24% in Phalombe as illustrated in the charts below.

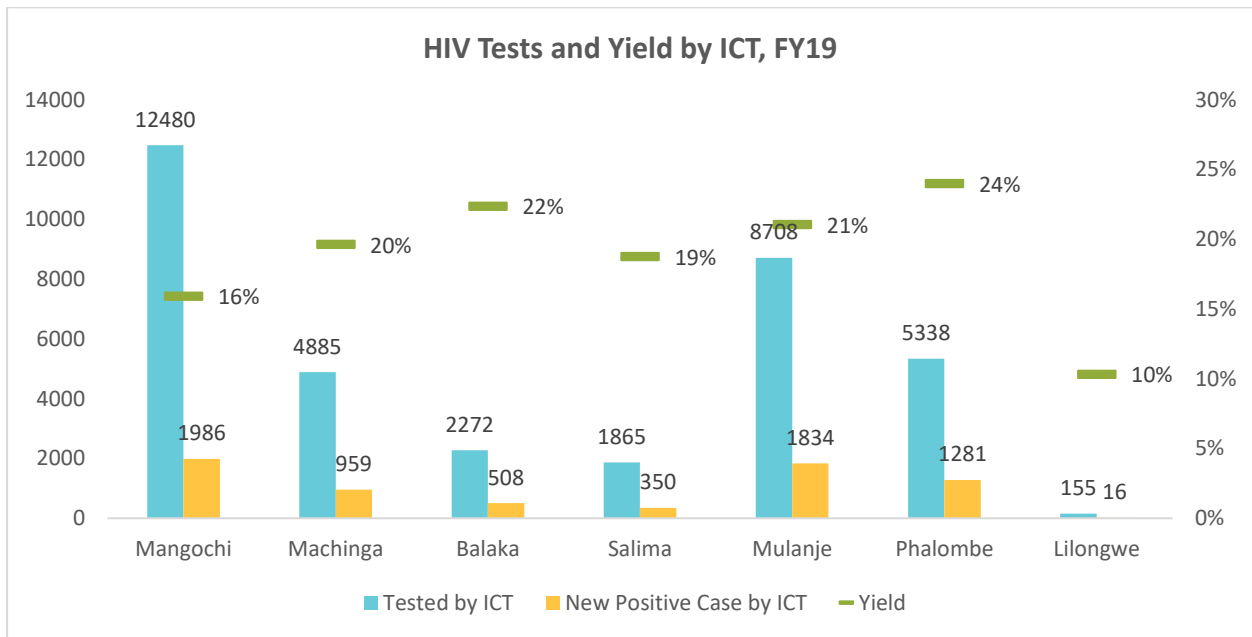


Figure 7: HIV tests by ICT and Yield from 7 district in FY 19

The proportion of new HIV positive cases identified from ICT was 23% of total tests (1,039,816) done in FY19. The figure below illustrates distribution of this proportion by district. While ICT takes a fair amount of effort and time, the program continues to prioritize implementation of ICT at all supported sites.

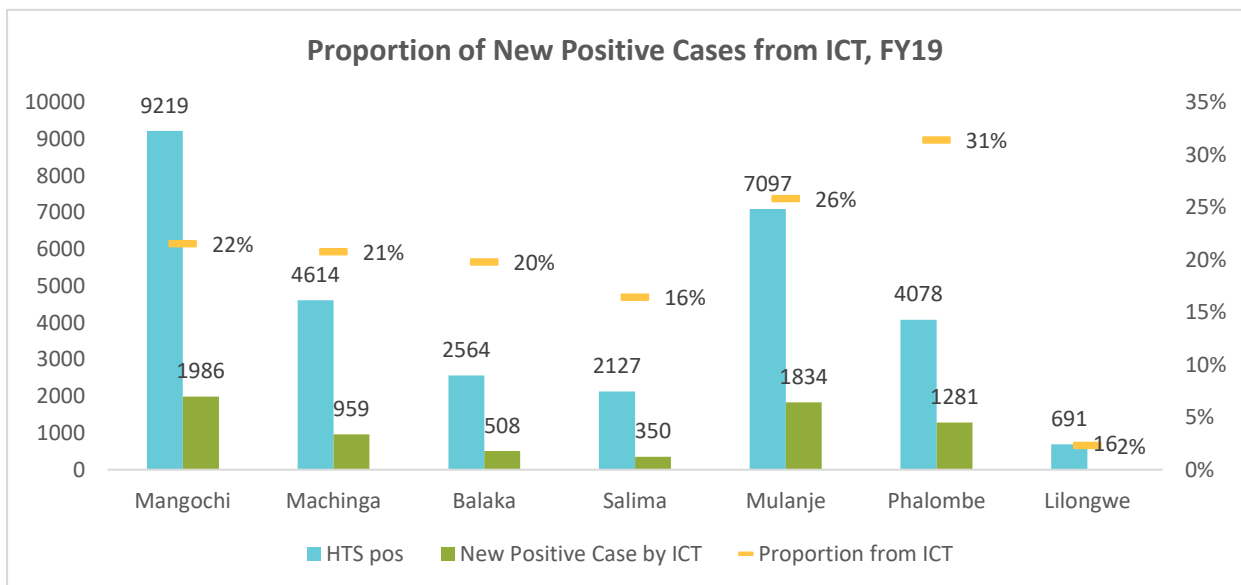


Figure 8: Proportion of new HIV positive cases from ICT in FY19

Tingathe continued to prioritize clients newly diagnosed with HIV, those with high viral load and ART clients with untested contacts for ICT in an effort to optimize testing yield. CHWs and HDAs provided ICT screening to index clients at both HTS and ART rooms. Clients in Mangochi, Machinga and Mulanje were offered VAPN as the primary referral method, and passive referral (family referral slips - FRS) as an alternative when VAPN was declined, and in the remaining four districts clients were offered FRS. For consenting clients, CHWs and HDAs continued to offer ICT services and follow up ICT clients and contacts to offer HIV test both at the facility and at home. In some sites, family

testing was conducted on weekends to ensure listed contacts accessed HTS at flexible and convenient timings.

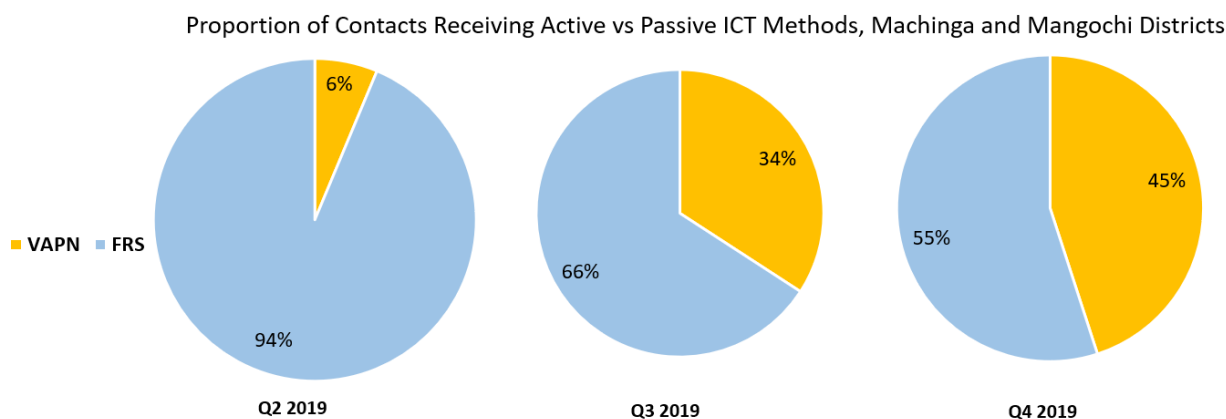


Figure 9: Proportion of contacts receiving active vs. passive methods, Machinga and Mangochi, Q2 -Q4 FY19

In FY 19, the proportion of clients receiving active method of ICT (VAPN) increased from 6% in Q2 to 45% in Q4 as illustrated in Fig. 9 above showing good progress towards ensuring increased testing for sexual contacts. Tingathe trained 595 staff to provide VAPN services in all supported sites in Machinga, Mangochi (in Q2) and Mulanje districts (in Q4). These included Tingathe staff (Coordinators, CHPOs, CHWs and HDAs) and MOH staff (ART providers and HTS Supervisors).

In the two acceleration districts of Mangochi and Machinga, contract referral was the most preferred VAPN strategy by Index clients, followed by provider and dual referral in that order. Nonetheless, its Provider referral that achieved the highest contacts return rate at 36% followed by dual referral and lastly contract referral at 32%. The highest positivity was attained in contract referral at 23%, followed by dual referral at 22% and provider referral at 17%.

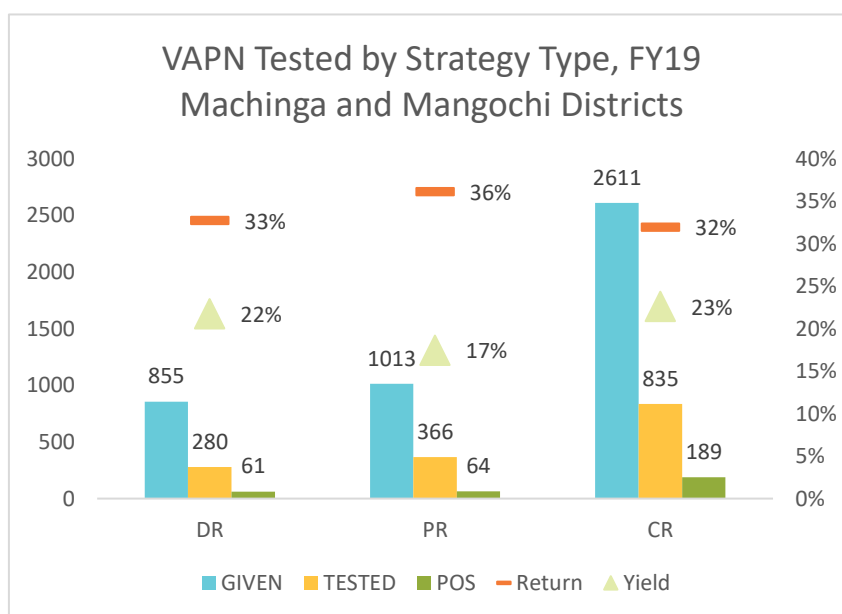


Figure 10: VAPN tested by strategy type in Q4 FY19

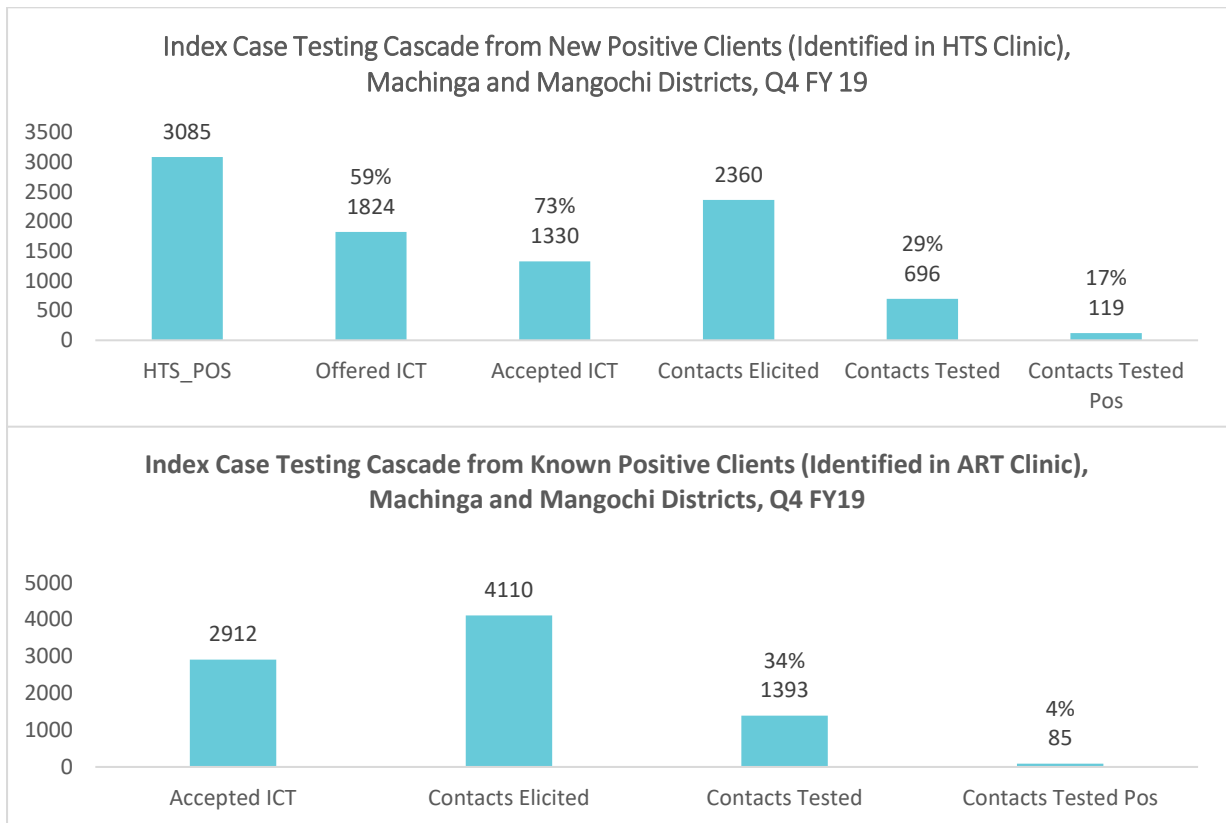


Figure 11: Index Case testing cascade from new positive clients in HTS & ART Clinics Q4 FY19 –Machinga and Mangochi

In Q4, Mangochi and Machinga districts achieved a low proportion of clients offered ICT in HTS clinic at 59%, however the ICT acceptance rate was high at 73% as shown in figure 10 above. The return rate was similar for VAPN contacts (33%) and Passive referral contacts (34%). In addition to ongoing ICT screening at HTS clinic, Tingathe intensified ICT screening in ART clinics in Q4 to elicit untested contacts of ART clients. As a result, almost double the number of contacts was elicited in ART clinic compared to HTS, with a similar higher return rate of contacts invited from ART clinic at 34% while that of contacts invited from HTS was 29%. ICT yield was high in VAPN contacts (17%) and in contacts from HTS clinic (17%) as illustrated below.

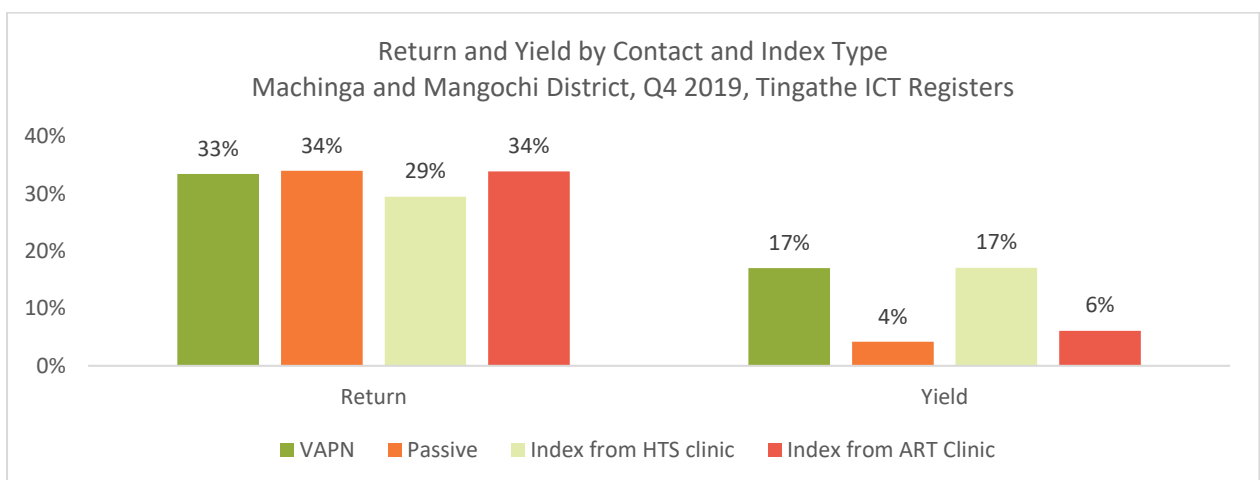


Figure 12: Contact return and yield by index type in Machinga and Mangochi districts, Q4 FY19

The number of contacts returning for testing with FRS and new HIV-positive cases identified through ICT in Machinga, Mulanje and Phalombe districts progressively increased from October 2018 due to improved counselling on ICT and correct documentation of index clients in ICT registers. CHWs were trained and deployed to provide patient level education on the importance of testing contacts of HIV-positive clients. Gatekeepers meetings were held in Machinga, Mulanje and Phalombe districts to introduce CHWs and their work in the communities to acquire buy-in from community leaders in quarter two. This facilitated the introduction of ICT services, allowing CHWs to begin home follow-up of index clients whose contacts did not return for testing. CHPOs and Site Supervisors provided supportive supervision, observed counselling sessions and provided feedback to CHWs and HDAs to ensure quality counselling and improved uptake of ICT. In addition remote supervision and monitoring was done via daily WhatsApp reporting on ICT implementation. Tingathe continues to work with sites to identify opportunities for improvement by addressing noted gaps along the cascade from screening all HIV positive clients for ICT, eliciting contacts, providing quality counselling to improve contact testing and focused follow up on ICT clients.

There was an important reporting change in quarter two for HTS_INDEX. The number of contacts tested is populated from the HTS registers by counting all persons tested who had a *partner positive* (as indicated in the HTS register). In previous quarters, Tingathe reported all persons tested with a family referral slip as a contact tested. This reporting change in quarter two led to an increase in the number of new positive cases identified through ICT.

SO 3a - Outreach for males and youth: Implementation progress

Targeted Community Testing (TCT) events were held in strategic locations to facilitate HIV testing for hard-to-reach populations, particularly men and youth, at convenient times and places in Mangochi, Machinga and Mulanje Districts. Populations with known high prevalence rates such as sex workers, fishermen, and bicycle taxi riders, and clients with limited access to testing were carefully selected and reached in specialized workplaces and social gatherings. Tingathe partnered with other organizations and influential leaders of key populations in organizing these TCTs. FY19, a total of 7,707 people were tested with 219 newly identified HIV positive, a yield of 2.8%.

An HIV testing yield of 7% was achieved in Mangochi district through a series of TCTs held in Q4 as depicted in the table. More men were tested (61%) than women, however yield was slightly higher in women (8.1%) than men (6.7%). The highest yield by target group was among female sex

| Targeted Community Testing by Target Group - Mangochi | | | | | |
|---|------------|------------|--------------|-----------|-----------|
| | Male | Female | Total Tested | Positives | Yield |
| Church Members | 13 | 39 | 52 | 3 | 6% |
| Estate Workers | 34 | 30 | 64 | 8 | 13% |
| Fisher folk | 361 | 141 | 502 | 37 | 7% |
| Herbalist Patients | 4 | 12 | 16 | 2 | 13% |
| Men | 21 | 0 | 21 | 1 | 5% |
| FSW and Clients | 8 | 18 | 26 | 5 | 19% |
| Workplace | 18 | 12 | 30 | 1 | 3% |
| Youth | 55 | 69 | 124 | 1 | 1% |
| TOTAL | 514 | 321 | 835 | 58 | 7% |

workers and their clients at 19%. Male wellness clinics offering HTS for men, in combination with other health assessments such as blood pressure and body mass index checks were conducted at Mangochi district and Monkey Bay hospitals in Q4 with an average attendance of 35 per site. The HTS yield from this clinic increased from 3.2% in Q3 to 4.4% in Q4.

HIV Self-testing continues to be an important strategy for identifying HIV positive men; self-test kits were distributed to women in antenatal clinic who did not bring a spouse during a visit. Distribution in STI clinic and during ICT also targeted women presenting without a partner with instruction to provide test kits to their spouses and sexual partners. In Q1 of FY20, Tingathe will revise and implement additional strategies for effective delivery of male friendly health services.

Youth testing in Mangochi district was done in collaboration with partners; AMREF and YONECO to provide testing services at five youth events in Q4. Most events tested children in school. A total of 160 youth were tested of which 51% were males. Only one positive was identified.

SO 3b - Outreach for KPs: Implementation progress

During this reporting period, TCT events targeting female sex workers were held in Machinga, Mangochi and Mulanje districts jointly organized with community partners YONECO and Pakachere. A total of 572 female sex workers were tested in the 3 districts, 23 tested HIV positive (5.3% yield). YONECO has drop-in centres where all newly diagnosed HIV-positive clients are referred for treatment services. In Mangochi and Machinga districts, HIV positive clients were referred to nearby health facility for treatment services. Tingathe program will continue to collaborate with partners to reach key populations with testing services and link all positives to treatment.

Active Case Finding challenges and responses for FY19

- Gaps in providers' comfort in offering ICT services, eliciting sexual contacts, counselling about disclosure and VAPN options, and how to approach a contact at home or by phone limited elicitation of sexual contacts and affected contact return for HIV testing. Tingathe continued to support facility teams through continuous professional development sessions, mentorship, and supervision to ensure delivery of quality services. CHWs and HDAs continue to struggle with ICT with many clients reporting that they have "no partner" or supplying incorrect locator information. A gradual process in internalising these skills is expected since it take time and significant practice to be fully competent. The program also revised the ICT training materials and mentoring approach significantly to address these gaps in follow up training focusing on counselling skills, utilizing counselling session observations and role plays.
- Limited space for offering HTS and ICT continues to be a challenge in a majority of the sites. Sites are encouraged to identify confidential, temporary space to be used whenever an HIV positive client is identified. ICT is handled by CHWs outside the testing room to avoid delaying HTS. Where available, Tingathe provided tents to be used as additional confidential space which, during off-peak hours for HTS, provided additional space for ICT counselling. Testing space was provided at Kawale and Area 25 health centres after ART clinics moved to new rooms at the site. Plans are at an advanced stage at A18 clinic to provide HTS space at the new clinic buildings. A total of 3 health facilities each in Balaka and Mangochi districts will benefit from recently approved plans for renovation of HTC rooms, which will ease the burden on the limited testing space. Construction works in 3 sites in Mangochi district will be completed in Q1 of FY20.

- Health providers' reluctance to refer clients for HIV test to avoid high workload remains a challenge. Tingathe will continue to provide morning testing service to decongest HTS queues by offering HTS before medical consultation starts during normal working hours.
- Futile client tracing efforts due to poor recording of locator information, clients deliberately giving wrong addresses, and clients who have moved present an ongoing challenge to successful ICT. CHWs and HDAs were reoriented on comprehensive recording of locator information was done e.g. phone numbers, home addresses including prominent landmarks. Routine mentorship and supervision by Coordinators and CHPO CHWs and HDAs reinforced correct documentation of locator information. CHWs and HDAs were also mentored on providing quality of counselling aimed at developing relationships that will facilitate honest sharing of information by index clients.
- Identification of clients who access HTS due to ICT referral or HIV self-testing continues to be a challenge, as some clients do not inform providers of their reasons for seeking testing services. HTS providers were mentored on good ICT counselling and encourage to ask clients about self-testing and ICT referrals to ensure that those who seek testing due to HIVST or ICT are correctly documented.
- Lack of Site Supervisors in 6 facilities in Phalombe and 10 sites in Mulanje district affected planning of case finding activities, particularly client follow-ups in Q1-3. Site supervisors were recruited and trained in Q4 to fill these gaps.
- Inadequate CHWs and HDAs to actively implement ICT (including contacts tracing) and community testing activities in Mulanje and Phalombe district presented a challenge; additional staff were recruited, trained and deployed in Q4 with additional recruitment to take place in FY20 Q1.
- Only one vehicle one vehicle each in Phalombe and Salima districts made mobility challenging to support all sites. Tingathe assigned one more vehicle to Phalombe district and continues to support Salima district with vehicles from the central office whenever needed.

Active Case Finding activities in the next quarter

| District | ACF activities |
|---------------|---|
| All districts | <ul style="list-style-type: none"> • Continue to prioritize ICT services for newly diagnosed HIV clients and HIV-positive clients with high viral load and reinforce screening for sexual partner contacts • Continue monthly site-level data feedback meetings to help sites develop plans to improve performance. • Continue providing self-test kits to women at ANC and at STI clinic for their untested partners as well as during ICT • Support the roll out of HIVST to remaining districts • Develop clear modalities of reaching men with HIV testing through TCT, HIVST and male friendly facility level services. • Continue scheduling of CHWs at ART clinic to screen clients with high viral load for ICT and clustering of ICT clients for follow-up at all sites. • Intensify supervision and mentorship to improve ICT documentation and counselling, obtaining good locator information for contacts |

| District | ACF activities |
|----------|--|
| | <ul style="list-style-type: none"> Enhance EID coverage by ensuring that exposed infants clinic appointments are aligned with mothers ART appointments and follow up documentation in the appointment register Support site supervisors to review and revise facility staff rotas to ensure efficient allocation of HDA and CHW tasks for maximum coverage and execution Training of HDAs on HIV recency training – Balaka, Mangochi, Lilongwe |
| Mulanje | <ul style="list-style-type: none"> Conduct facility-based HIV self-testing orientation for Tingathe and MOH staff and commence distribution of HIVST kits at all sites Engage community partners (COWLHA, GAIA, MAGA) for HIV testing of men and youth at hotspot areas, social/cultural gatherings and communities |
| Mangochi | <ul style="list-style-type: none"> Hold regular review meetings with Community Partners; One Community and PSI to monitor community follow-up of ICT clients and or their contacts. From Q1, One Community and PSI will be responsible for following up ICT clients and their contacts in 21 catchment areas overlapping with Baylor in Mangochi. Start distributing self-test kits during Teen Clubs to all teens 13+ years of age who meet the criteria for distribution. These can be shared with a sexual partner or the friend of TC clients who feel they have been at risk. |
| Machinga | <ul style="list-style-type: none"> Utilize recency testing results to prioritize clients recently infected in ICT follow up/testing as these clients are likely to transmit HIV infection. Hold regular review meetings with Community Partners; One Community and PSI to monitor community follow-up of ICT clients and or their contacts. From Q1, One Community and PSI will be responsible for following up ICT clients and their contacts in catchment areas overlapping with Baylor in Machinga district. |
| Salima | <ul style="list-style-type: none"> Collaborate with other partners in targeted community testing to test more men Reinforce OPD screening criteria to all sites; offering HIV test to OPD clients who never tested, tested more than a year ago and all men > 25years of age. |
| Phalombe | <ul style="list-style-type: none"> Recruit, train and deploy additional HDAs and CHWs to fill vacant posts Roll out VAPN services in Q1 FY20 Roll out HIV ST services in Q2 FY20 |
| Balaka | <ul style="list-style-type: none"> Continue optimising ICT through clustering ICT clients and assigning a CHW to each cluster for follow-up. Monitor PITC progress and support the lower-performing facilities. |

Active Linkage and Retention

| SO # | SO | Explanation |
|------|-------------------|---|
| 4 | Linkage | Ensure >=95% linkage to ART and retention through the first 6 months of ART through data driven linkage-to-care strategies, with a focus on improving linkage and retention among men and youth |
| 5 | ART initiation | Quality ART service delivery, including Dolutegravir transition |
| 6 | Retention in care | Scale-up proven ART retention interventions to achieve very high levels of ART retention, with a focus on improving retention among men and youth |
| 7 | Adolescent Care | Increase access to high quality to adolescent and young person services |

| | | |
|---|-------------------------------|---|
| 8 | Differentiated Models of Care | Scale up differentiated services delivery models, including male and youth friendly models, with fidelity |
|---|-------------------------------|---|

SO 4 - Linkage: Implementation progress

Tingathe achieved a high rate of linkage to care in FY19 in all supported districts. Out of 30,457 people diagnosed with HIV in the year, 29,202 (96%) clients were initiated on lifesaving antiretroviral therapy (ART) achieving 85% of the annual target (29,202/34,284). The figure below shows clients linked to ART by district in FY19.

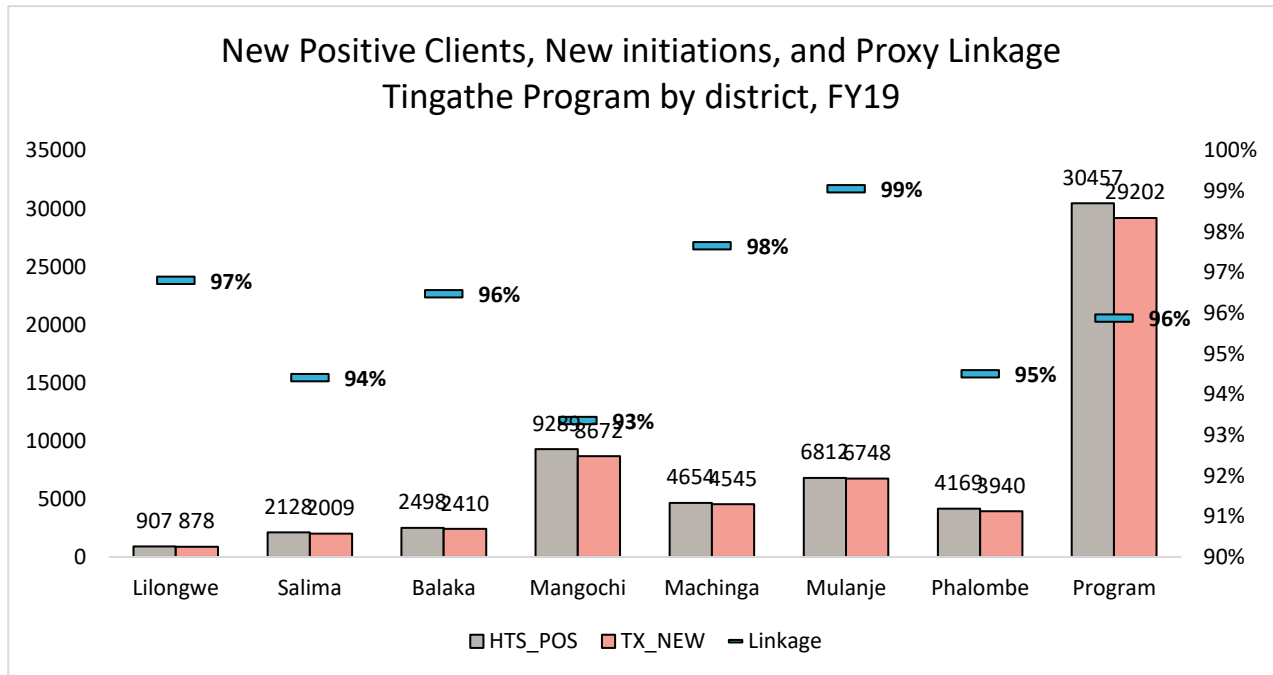


Figure 13: ART linkage per district, FY19

In this reporting period, CHWs provided pre-ART counseling which facilitated informed choice for ART initiation. They recorded comprehensive locator information to facilitate follow ups. CHWs also conducted active follow-up of clients who did not start ART within two weeks of HIV diagnosis as well as those who miss appointments. They used the appointment registers to record clinic bookings for ART clients and followed through to identify clients who missed appointments. In addition, CHWs, HDAs and clinicians jointly participated in outreach clinics and TCT in selected sites. This ensured that all those testing HIV positive were provided pre-ART counselling and received same day initiation on ART. The linkage focal persons (a selected CHW at each site) reported the number of new positive clients initiated on ART on a weekly basis out of the total number of HIV-positive clients identified each week. The site supervisors kept track of this linkage data and ensured follow ups were made for clients opting not to start same day ART for various reasons. Linkage performance and improvement plans were discussed during monthly feedback loop meetings for each site.

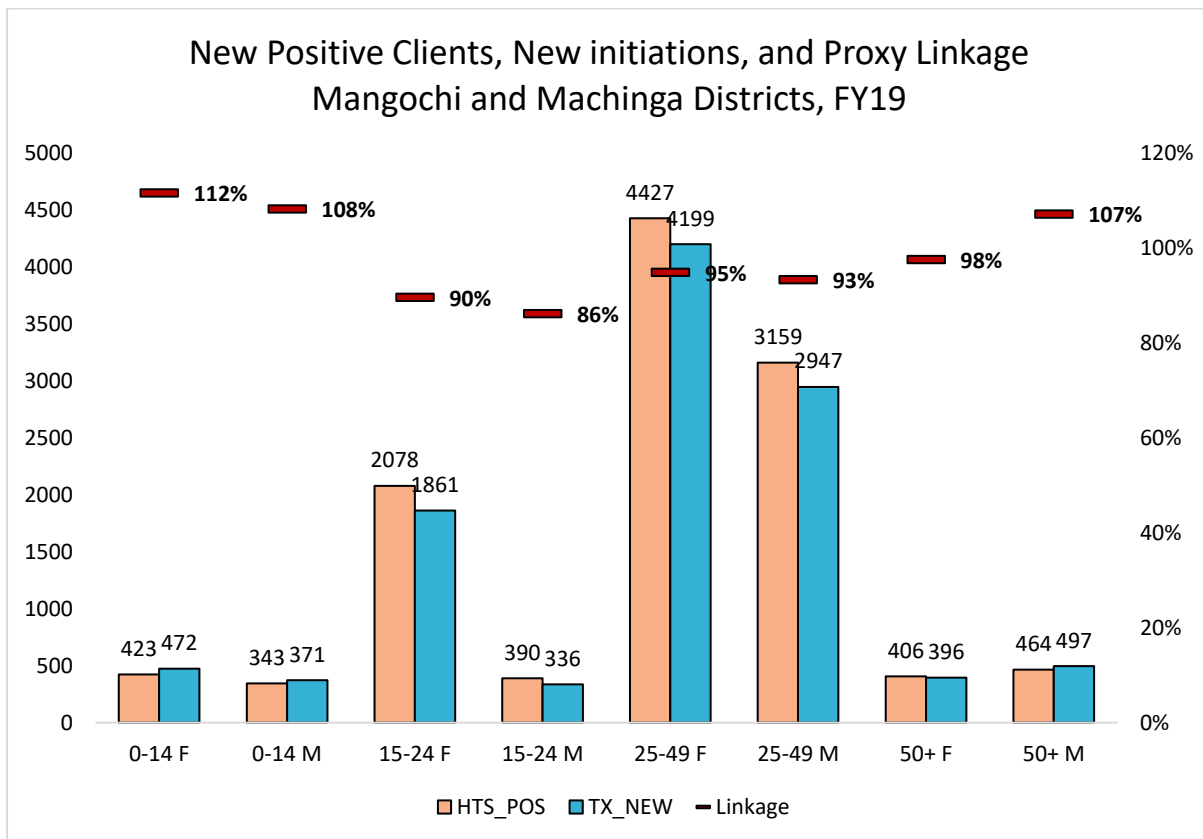


Figure 14: Linkage by age and sex, FY19

In FY 19, Tingathe achieved a linkage rate of over 85% across all age groups and sex. Several interventions were put into place to achieve this: Tingathe developed pre-ART talking points to improve counselling that enabled clients to make an informed choice to start treatment. Coordinators intensified mentorship to ART providers and CHWs to tailor counselling messages to clients by age group when providing pre-ART counselling sessions to ensure they provide the necessary information and support to start ART. For clients not ready to start treatment immediately upon diagnosis, CHWs collected locator information and conducted active follow ups through phone calls and home visits to ensure they are started on ART within two weeks of diagnosis. The majority of Tingathe-supported health facilities provided daily initiation of ART which contributed to high linkage rates.

SO 5 - ART initiation: Implementation progress

Tingathe staff supported initiation and transition of eligible clients to dolutegravir (DTG) based HIV treatment regimens in all supported sites in 7 districts. Tingathe developed talking points on DTG to standardise information provided to clients in all sites. CHWs and HDAs provided health talks on DTG transition during ART clinic days to dispel misconceptions associated with this regimen. Prior to initiation, one on one or group counselling was provided on benefits of DTG. By the end of September 2019, a total of 104,282 HIV positive clients were transitioned to tenofovir/lamivudine/dolutegravir (TLD), this represents 57% of the adult cohort transitioned to TLD in 6 supported districts¹. As shown in the figure below, each district recorded a gradual increase from one quarter to the next.

¹ Lilongwe is excluded because Tingathe is only responsible for Pediatric ART and PMTCT

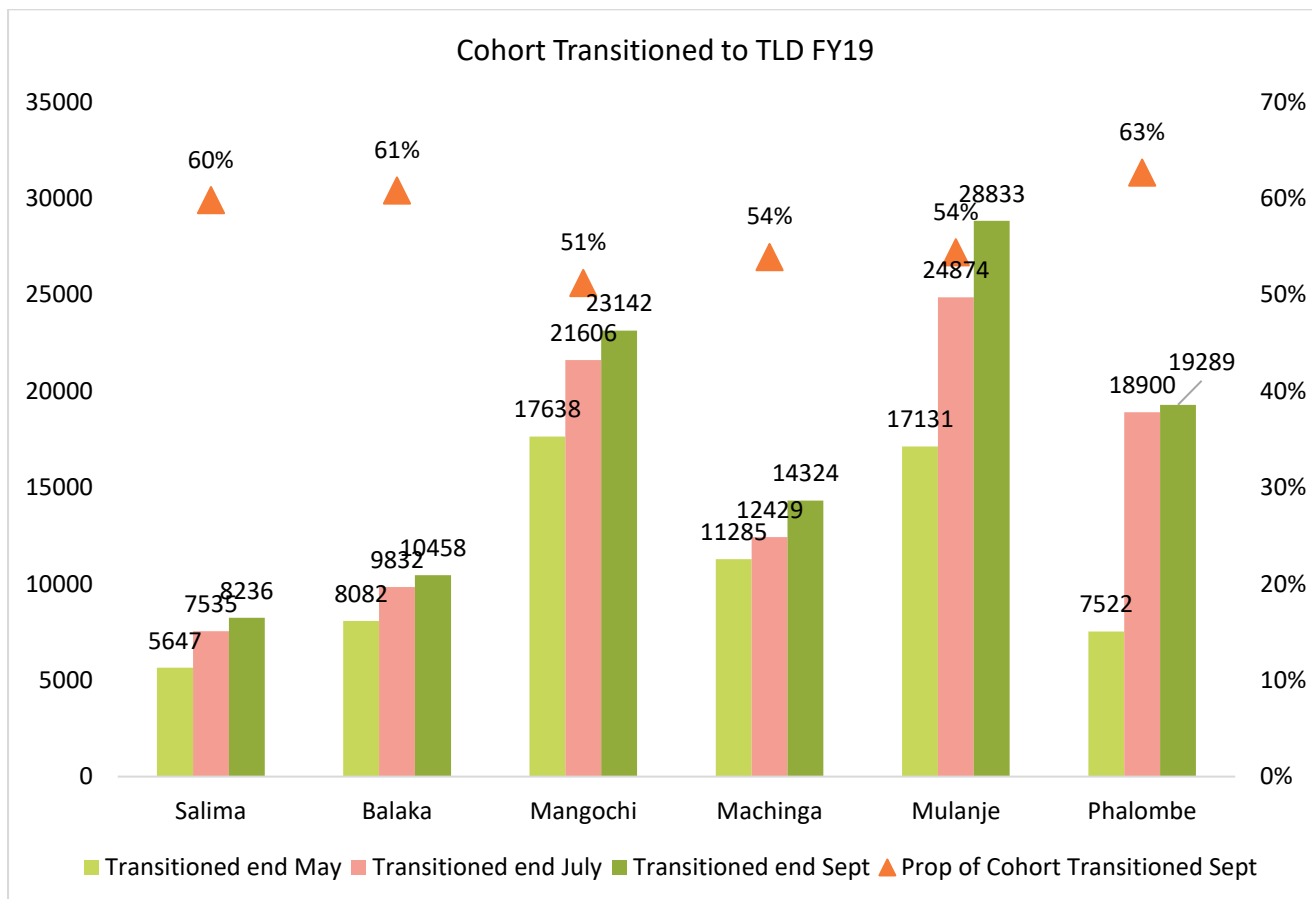


Figure 15: Cohort transitioned to TLD FY19

SO 6 - Retention in care: Implementation progress

Tingathe promotes retention of clients on ART through provision of high-quality, client-focused education, counseling, and client support to overcome barriers to adherence and retention. To address client retention particularly during the early stages of ART initiation, Tingathe developed updated versions of pre-ART and ART counselling sessions for the first six months of initiation. This is a period noted to have high rates of default as clients struggle to cope with their new diagnosis and reality. New HIV clients undergo a series of pre-ART and ART counselling sessions to enhance adherence. All new clients were assigned a CHW for long-term follow up until first VL is drawn at six months and VL is suppressed. During this time, pre-ART and ART counselling was provided during month one, two, three and six. The new clients were also enrolled in intensified care ART clinics (ICAC) where a clinician monitored them closely and provided the necessary ART support. Where they are available, full-time district psychosocial counsellor provided support to clients newly initiated on ART to promote retention in care.

Tingathe assigned cohorts of newly diagnosed clients in a month to one CHW to promote follow up and client support through monitoring clinic visits and counselling. Appointment registers were reviewed to identify and track clients who miss appointments and a follow register used to track clients listed for follow-up. In FY19, Tingathe updated the follow up register to include tracing attempts to enhance monitoring of follow up phone calls and visits to clients. CHWs reviewed appointment registers continuously to identify clients who missed appointments. Those who do not attend clinic within a week of their scheduled visit are documented in the community health worker follow up register, and if they do not attend clinic by 2 weeks after the appointment, tracing is initiated (via phone first if available, followed by a home visit).

CHWs interviewed ART clients who missed appointments to establish reasons for missing appointments. Some of the common reasons given included being away for work, lack of transport, had pills remaining, did not know how to read appointment date, forgot appointment date, was attending a funeral, and feared being scolded by the service provider among others. CHWs engaged the clients for possible solutions to prevent recurrence of missed appointments and default, dispelled all misconceptions, reassured clients and brought them back to care.

Differentiated service delivery was implemented for stable clients in all supported districts. These models allowed for flexible ART attendance modalities to improve retention. DSD is discussed in detail in following sections.

Active Linkage and Retention challenges and responses

| District | Active Linkage and Retention challenges and responses |
|---------------|--|
| All districts | <ul style="list-style-type: none"> ● Resistance to transition clients to DTG despite the new circular advocating for client switch to DTG based regimes, there is pressure to hold back on some transitions until the 5A stocks are depleted. By the end of Q4, an agreement was reached to initiate newly diagnosed HIV patients and teens to DTG. ● Knowledge gaps about eligibility for DTG transition by untrained ART providers. Continued mentorship to providers on DTG transitioning including side by side case reviews for transition, as well as reinforcement of the different DTG-based regimens available for adults vs children/teens. ● Understanding the role of DTG for women has been a challenge due to changing messaging about DTG side effects in pregnancy. The program developed clear messaging to be included in health talks and for providers to clarify misconceptions and allow women to choose what regimen is best for them. ● Use of incorrect addresses/locator information by clients which makes it difficult to trace them during follow up. CHWs have been mentored to provide quality Pre-ART counselling to improve information collected from clients ● Poor documentation in the appointment register leading to failure of CHWs to note missed appointments. Mentors continue to work with CHWs on documentation and conduct facility based CHW CPD meetings. Intensified supervision efforts will be undertaken in Q4 and the collection of CHW tracing data will ensure individual CHWs are held responsible for poor documentation ● Poor linkage for HIV positive clients identified through community testing; TCT. TCTs have been restructured to ensure that an ART provider accompanies the team at every TCT for access to ART initiation. Continued coordination with community partners will ensure clients are well counselled to come to the facility for ART initiation ● The need for disclosure of HIV status to partners prior to ART initiation remains a problem, especially for women who refuse to start until their husbands are informed. The VAPN strategy has simplified the disclosure process as more assisted methods are available. ● Poor outcomes among children on LPV/r pellets related to poor tolerance/adherence, high default rate, low VL suppression rate |

| District | Active Linkage and Retention challenges and responses |
|----------|---|
| | <ul style="list-style-type: none"> - Attached every client to a CHW; CHW ensure the clients return to the clinics, provide a home visit where necessary - Monthly audit exercise to track progress |
| Mulanje | <ul style="list-style-type: none"> • Health facilities bordering Mozambique (Muloza, Mpala, Milonde, and Namasalima) have clients coming from Mozambique hence they are difficult to trace. CHWs are encouraged to collect functional phone numbers for clients residing on Mozambique side of the boarder for easy follow up where possible. Patients testing positive for HIV are offered pre-ART counselling, those ready are initiated and transferred to a facility of choice in Mozambique if they so request. |
| Mangochi | <ul style="list-style-type: none"> • Inconsistent reporting on AM clinics and 6-month scripting led to underreporting. Mentorship by coordinators and M&E in Q4 ensures accurate and consistent documentation moving forward. • Some clients come from hard to reach areas e.g. Chiphole which is the catchment area of Lulanga health facility hence hampering efforts to active linkage and retention of clients. |
| Machinga | <ul style="list-style-type: none"> • Challenges with cross-partner collaboration in looking for people who have not started treatment. Tingathe continues to take initiative to coordinate with other partners on HIV care issues including linkage to treatment • Field testing use of a video as a health-talk tool– we hope this may improve adherence and retention in long-term (possibly also suppression among children failing due to poor adherence) |
| Phalombe | <ul style="list-style-type: none"> • Insufficient numbers of CHWs to follow up clients who do not start ART immediately or miss appointment and defaulters. Recruitment process for additional staff is underway. |
| Balaka | <ul style="list-style-type: none"> • As a sustained district, there is a relative lack of resources to ensure providers are available on the weekend resulting in some missed opportunities to initiate treatment. This was addressed by providing allowances to MOH providers at select sites in Q4. |

Active Linkage and Retention activities in the next quarter

| District | Active Linkage and Retention activities in the next quarter |
|---------------|--|
| All districts | <ul style="list-style-type: none"> • Continue providing enhanced support to clients newly initiated on ART which includes assignment of a CHW to all new HIV+ clients for on-going follow, enrolment in intensified care ART clinic and a special counselling curriculum. • Continue to book all new HIV diagnosed clients on ICAC days for special care to improve retention. • Monitor DSDs through organized data collection and reporting. • Ensure all sites have a specific CHW (linkage focal person) to daily generate names of clients not linked to ART for tracing through home visit or phone calls • Support MOH Scale up of 6 Multi-Month Scripting (6MMS) to additional sites in all districts |

| District | Active Linkage and Retention activities in the next quarter |
|--------------------------|---|
| Mulanje | <ul style="list-style-type: none"> Maximise “Back to Care” exercise at all 22 sites where CHWs are tasked to follow up all clients not linked to care, missed appointments and defaulters. Monitor the implementation and documentation of ART counselling 1,2,3 and 6 by CHWs in 21 sites (excluding Mulanje mission hospital – no program staff at site) Allocate a CHW to accompany community testing partners to ensure that all new positive cases are linked to care from the community to a facility. Continue assessing and addressing reasons for missed appointment |
| Mangochi | <ul style="list-style-type: none"> At MDH, revamping of focal person activities: 1) Establishing weekly meetings at the facility in Q4 where focal persons report on activities they oversaw in the previous week and progress related to QI activities. The team will ten brainstorm ways to improve on gaps. 2) Each focal person will have specific objectives for their activity in order to aid in the efficient carrying out of their roles and accountability from their supervisors. |
| Lilongwe | <ul style="list-style-type: none"> Provide ART counselling sessions for all new clients on ICAC days at month 1, 2, 3 & 6 as groups or individual |
| Balaka, Phalombe, Salima | <ul style="list-style-type: none"> Establish and/or scale up ICAC clinics in all facilities |

SO 6 a - Adolescent care: Implementation progress

Teen Club: In FY19, Tingathe oriented three new districts (Machinga, Mulanje, and Phalombe) to teen club programming and management with emphasis on enrolment criteria where all teen attending teen clubs needed to have undergone disclosure counselling. Bi-monthly support to teen clubs continued in 6

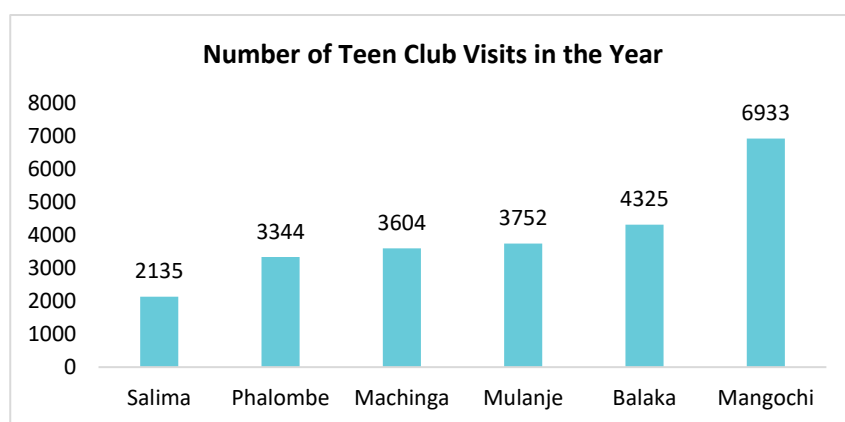


Figure 16: Number of Teen Clubs in FY19

supported districts, were a total of 24, 093 adolescent visits were made to 59 teen clubs: 12 in Mulanje, 11 in Phalombe, 13 in Mangochi, 5 in Balaka, 6 in Salima and 12 in Machinga.

Coordinators focused on quality clinical care with focus on monitoring appointments using the appointment register, screening for index testing, viral load screening and appropriate change to second line for eligible adolescents as well as continued psychosocial support activities. Tingathe also introduced the new Teen Club register in all districts, which emphasizes viral load monitoring and management of those with high viral loads.

Youth Mini Symposium (Teen Club Intentional Programming Training): Youth Mini Symposium sessions were conducted for site level staff from facilities with teen clubs in Phalombe, Mulanje and

Machinga. A total of 136 teen club mentors were provided information to improve teen club programming for better health outcomes for adolescents living with HIV. The symposium produced the following take home messages; 1) only fully disclosed teens are to be enrolled in teen club. Participants perfected their skills in conducting disclosure process for all undisclosed teens. 2) To MOH nurses and clinicians will be supported to take a leading role in managing adolescents with complex clinical issues including making clinical decisions to switch medication for those with treatment failure 3) CHWs should be engaged in teen club activities to help triaging and TB screening.

Disclosure trainings: Two-day disclosure trainings were conducted in Mulanje, Mangochi and Machinga to equip facility staff on disclosure processes and counselling skills. A total of 135 facility staff were trained in adolescent care with a focus on the disclosure of HIV status to infected children in an age-appropriate manner. These trainings helped to address identified gaps by strengthening the capacity of health workers in conducting partial and full disclosure sessions at site level and handling of psychosocial issues affecting adolescents living with HIV. The training incorporated role plays, to provide an opportunity for participants to practice and gain confidence in conducting disclosure processes.

Youth Supporter(YS) Program: Tingathe conducted supportive supervision and mentorship visits at all five sites in Mangochi, Salima and Balaka districts to monitor progress and provide remedial solutions to identified gaps. YS navigate youth through facility services including HIV testing and ART for ALHIV. Youth supporters are leading the process of identifying youth living with HIV and are supporting them to start ART and remain in care. Those who decline to be linked to treatment are referred to the psychosocial counsellors for support and are followed up to encourage them to begin ART. Youth supporters are helping youth needing viral load tests to have their samples drawn. The youth supporters are also providing psychosocial support, including disclosure sessions and adherence counselling, and are addressing stigma and mood disorders. YS review meeting was conducted in Mangochi for experience sharing, clinical updates and practical training sessions.

Adolescent care challenges and responses

- Some teen clubs had undisclosed teens enrolled. Mentors and service providers were trained to formalize the disclosure process for all undisclosed teens already attending and to make sure they verify disclosure prior to enrolment of new teens.

Adolescent care activities in the next quarter

- Conduct disclosure training in Mulanje
- Continue support for teen club activities
- Continue to support youth supporter program

SO 6 b - Differentiated models of care: Implementation progress

Tingathe implemented differentiated HIV service delivery (DSD) models in the 7 supported districts to enhance retention in HIV care services (table 2).

Table 2: Types of differentiated models of care implemented in FY19

| DSD | District & Sites where it is implemented & when it was implemented and achievement in FY19 | Frequency of the clinic | Enrollment criteria |
|---------------------------------------|--|--|---|
| 1. 6 multi month scripting (6MMS) | Machinga: Machinga District Hospital started in April 2019. A total of 1,424 clients were seen | Every clinic day | <ul style="list-style-type: none"> Stable clients on ART with no medical complications |
| | Mangochi : Mangochi District Hospital, a total of 978 clients are receiving 6 monthly refills | | |
| | Mulanje: Mulanje Mission Hospital and Mulanje District Hospital, 3,992 clients got 6monthly refills | | |
| | Salima : Salima District Hospital; 221 clients receiving 6 monthly refills | | |
| 2. Intensified Care ART Clinic (ICAC) | Machinga: 18 sites with established ICAC, 1,533 clinic visits done | Weekly at the district hospital and monthly at the rest of the sites | <ul style="list-style-type: none"> Children 0 to 10 years old and guardian Adolescents 13 to 18 years old if no teen club Clients with a high viral load Clients newly initiated or re-initiated on ART Clients with TB (confirmed or suspected) Clients with malnutrition. Clients with new Opportunistic Infections Clients admitted to hospital in past 3 months |
| | Mulanje: Established at 21 sites in Q3. 801 clients attended ICAC in Mulanje | | |
| | Mangochi: Established in 36 sites. 826 clients were seen at ICAC | | |
| 3. Men clinic | Machinga: Mangamba HF and Ntaja HF: Total of 1,977 clients | Weekly and Monthly (depending on site workload) | <ul style="list-style-type: none"> Men |
| | Mangochi at MDH and MBH 97 men attended the clinics, and received HTS, 44 HIV positive | | |
| 4. Extended-hours ART clinic | Machinga : 1,150 clinic visits made at DHO | Every clinic day | <ul style="list-style-type: none"> All |
| 5. Nurse-led ART clinic | Machinga at Chipolonga, Chikweo 299 visits | Monthly | <ul style="list-style-type: none"> Stable clients on ART with no medical complications |
| | Mangochi : clinic established in 2 sites, 142 clients attended clinic | | |
| 6. Teen club | Machinga, Mangochi, Balaka, Phalombe, Salima, Mulanje, See SO 10: adolescent care Section | Bi- monthly | <ul style="list-style-type: none"> Disclosed teens from 10 years |
| 7. Prison mobile ART clinic | Mulanje : 214 inmates were provided services and 49 VL samples drawn | Monthly | <ul style="list-style-type: none"> All ART clients |
| 8. Early Morning clinics | Mangochi MDH 3,470 clients attended clinic | Weekly | <ul style="list-style-type: none"> All ART clients |

To support delivery of these DSD services at district level, Tingathe implemented the following activities:

- Orientation of providers to the various DSD models was done during facility level and district ART review meetings to build MOH capacity and reinforce ownership of DSD activities, including briefing of MoH leadership (extended DHMT) prior to roll out of DSD services at facilities with high volume of clients and invitation to DHMT staff to join service delivery activities in order to promote ownership.
- Site level CPD sessions were conducted at select sites to facilitate roll-out of complex models like ICAC, followed by ongoing targeted mentorship and clinical support at all ICAC clinics
- Provision of reference materials and job aids to facility staff, including ICAC referral posters containing eligibility criteria for specific DSD models/clinic
- Provision of SOPs, job aids on the new ART guidelines at ART clinics; allowing for quick reference
- Oriented sites on standardized reporting approaches for the DSD models to enhance reporting.

General challenges with implementation of DSD models of ART care

- Scheduling challenges are present across all DSD models, ranging from the complexities of aligning mentorship schedules across multiple facilities to ensure an experienced provider is always available for ICAC to the challenges associated with timing viral load testing and results for clients receiving 6-month scripting.
- To address the challenges with scheduling ICAC, the program has successfully lobbied MOH to have some facilities hold ICAC clinics on a different day, room or time from the regular ART clinic based on availability of staff and space at the health facility.
- Insufficient number of trained providers at most sites result in challenges ensuring that a trained provider is available to join a mentor at all ICAC clinics. Mentors encourage facility staff to join clinical mentorship to learn to improve quality of care for PLHIV.
- Lack of MOH facility ownership of the DSD initiative: due to multiple competing priorities, facility MOH staff view DSD models as Tingathe initiatives rather than MOH, initiatives and demand allowances. Mentors continue to negotiate with staff and district leads with DHMT members to advocate for site level participation without allowances.
- Low turn-out at nurse led outreach ART clinic in Q3 is due to associated stigma compared to facility ART clinic where services are integrated. Tingathe will keep monitoring the Nurse led clinic attendance in Q4 to determine whether this model should be continued in FY20.

DSD related activities in the next quarter

- Roll out ICAC clinics to remaining sites in Machinga, Mangochi, Salima and Phalombe districts
- Monitor DSD through data collection and reporting on monthly basis

Viral Suppression

| SO # | SO | Explanation |
|------|-------------------------------|--|
| 7 | Viral load testing coverage | Scale-up access to high quality viral load testing according to the national guidelines to reach >90% of eligible clients with a viral load test |
| 8 | Viral load cascade management | Ensure return of viral load results to care providers and patients and appropriate management of high viral load |

SO 7 and 8 - Viral load testing coverage and cascade management: Implementation progress

Tingathe achieved 87% viral load coverage, with a viral suppression rate of 86% in FY19. The annual period saw revision of VL guidelines to recommend annual VL sample draw starting April 2019, leading to increased VL coverage in Q3 and Q4. The graph below shows FY19 VL coverage and suppression by district based on laboratory information management system (LIMS) database.

Tingathe implemented multiple approaches to enhance VL monitoring to produce a remarkable improvement in viral load coverage over the fiscal year. Facility client flow was adjusted to ensure eligible clients received viral load draw prior to seeing the clinician while maintaining their place in the queue rather than waiting until their clinic visit was complete. Early morning (before official services begin) viral load sample collection was scaled and maintained in all supported sites to reduce waiting time. These changes minimized the loopholes allowing clients to exit the clinic before getting a viral load done. CHWs screened clients' health passports and master cards during clinic days and referred eligible clients for viral load sample collection. Supported districts used WhatsApp messaging to provide remote supervision and allow coordinators and district leadership to monitor daily uptake of viral load and make ongoing adjustments as necessary. Data feedback meetings and viral load audits were conducted in supported sites which facilitated development of site-specific plans to improve VL coverage and management of clients with high viral load. In Q4 a site supervisor monthly VL checklist was developed to assist sites troubleshoot and implement actions to address VL gaps.

Paediatric VL coverage was higher in females than males with the exception of Mangochi where similar coverage rates were seen in females and males. This trend is similar among adults, performance against target for men is lower than women due to poor health seeking behaviour among men and challenges in male case finding.

Figure 17: Tingathe FY19 routine VL cascade (data source: LIMS)

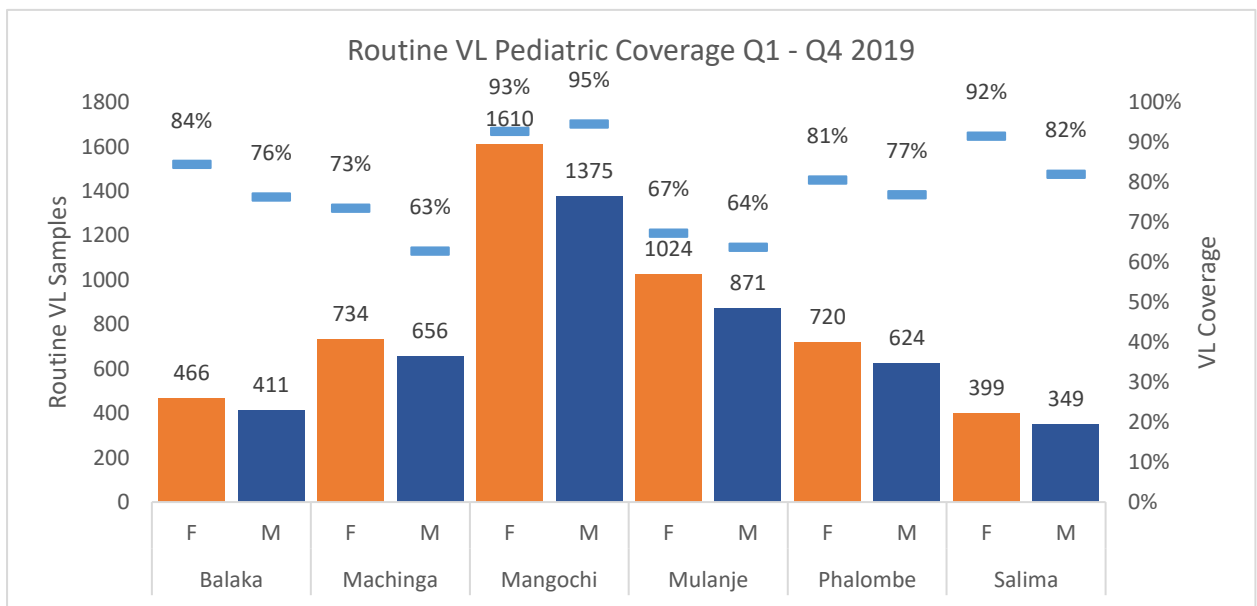


Figure 18: VL Coverage by age, sex, district for clients <15years (Data source LIMS)

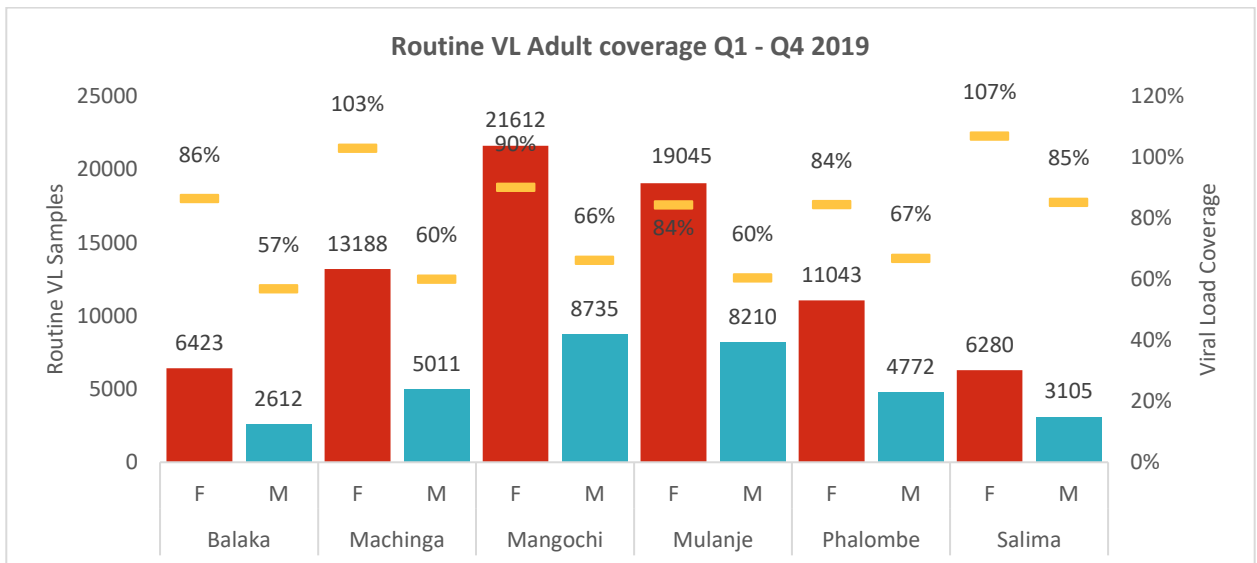


Figure 19: VL Coverage by age, sex, district for clients >15years (Data source LIMS)

As illustrated in fig. 20 below, suppression rates remain higher among adults than among children and adolescents.

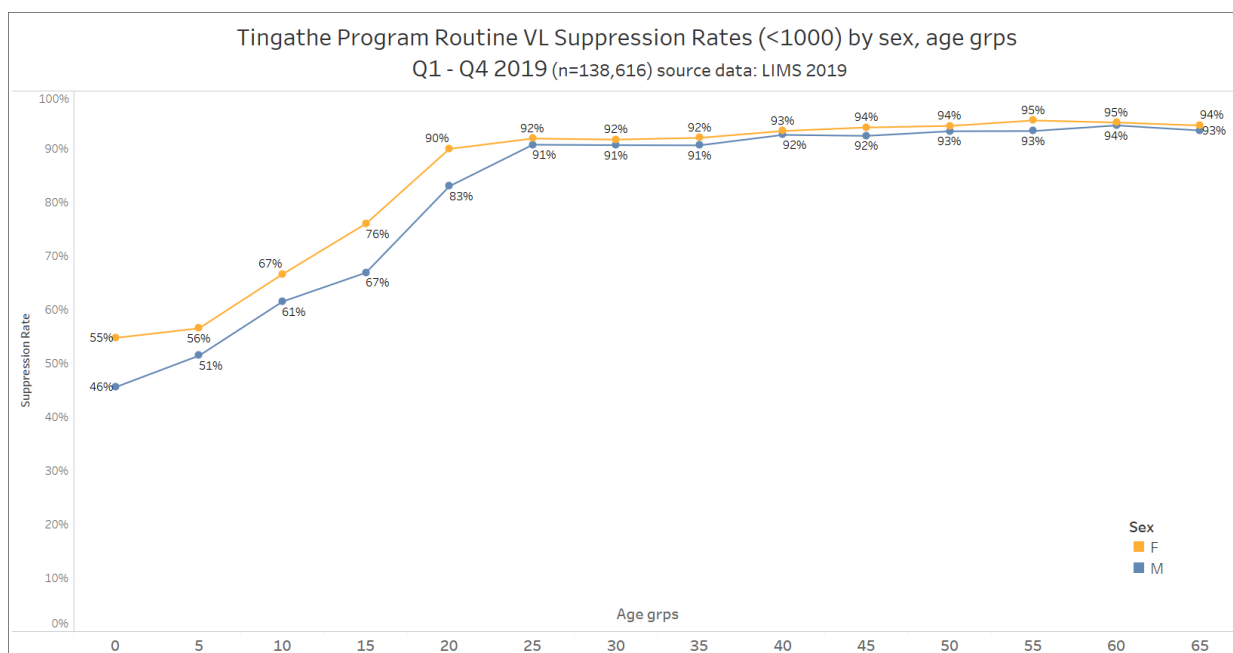


Figure 20: Routine VL suppression (<1000c/ml) by sex and age groups (Data source LIMS)

To address the lower viral suppression rate among children and adolescents, the program conducted CPD sessions for health care providers, started enrolling children in ICAC clinic to ensure that regimens are changed as weight changes, provided health education to guardians on importance of child weight monitoring during every clinic visit and empowered them to remind clinicians about it, and review of pediatric treatment optimization strategies including how to optimize treatment using LPV/r pellets. Further, specialized age-appropriate counselling was provided to clients, VL monitored and regimens changed appropriately. In addition, teen club sessions were held incorporating health education to guardians and caregivers.

Tingathe developed tools to improve ART counselling and intensive adherence counselling (IAC). The tools comprise talking points and provide guidance for providers to follow when counselling ART clients; before they start treatment- pre ART, follow up months 1, 2, 3, and 6 after initiation on treatment and IAC using the Information Motivation and Behaviour Change (IMB) approach. The tools ensures provision of quality counselling by focusing on needs of different age groups and sex, with the goal of improving viral load suppression for all ART clients.

At district level, various activities were implemented to improve viral load cascade management, including provision of intensive adherence counselling (IAC), implementation and scale up of Intensified Care ART Clinics (ICAC) which allow clinicians to spend more time with clients requiring additional clinical reviews/care – high VL, suspected clinical failure, management of co-morbidities such as chronic diseases and malnutrition etc and support for advanced HIV care provision. Further, intensive mentorship was done to MOH providers and lay health care workers to help them understand eligibility criteria for VL testing, enrolment and management of clients in ICAC. To improve their skills on IAC, at Mulanje district hospital, CHWs were paired with an experienced IAC counsellor for side by side mentorship. With the establishment of ICAC, all HVL cases were seen in

this special clinic. Daily WhatsApp reporting on viral load coverage from facilities provide real-time remote supervision and troubleshooting to address loophole in daily VL uptake.

In FY19, the Laboratory Information Management System (LIMS) which hosts the main database for the EID and VL testing program was decentralized into a hub automation system. The interconnectivity was successfully installed in the districts of Mulanje, Mangochi, Machinga and Phalombe DHO laboratories in collaboration with MoH and support from Clinton HIV AIDS Initiative (CHAI) and University Research Center (URC). The system connects the district labs directly to the LIMS network. It allows entry of all viral load and EID sample information at DHO lab workstations and viewing of results in real time. Samples are transported by Riders for Health under URC to the molecular labs for processing and approved results made available for direct printing at the hospital labs using thermal papers. This has led to 50% improvement in turnaround time for results from an average of 21 days prior to connection to approximately 7-14 days post connection.

Viral Suppression challenges and responses

| District | Viral Suppression challenges and responses |
|---------------|--|
| All districts | <ul style="list-style-type: none"> • Drug formulations for children: Pellets, granules and syrup not widely available for children diagnosed with HIV infection. Administration of tablets remains a challenge with guardians crushing or dissolving LPVr tablets thereby affecting potency and contributing to development of resistance. Tingathe staff continue to educate guardians on drug administration, providers to reinforce this during clinic reviews. The program will continue to support adherence and support the roll out of LPV/r granules as it rolls out in FY20. • Not all eligible clients were offered viral load testing, due to lack of client education, clinic flow challenges, and inconsistent screening practices. To address these issues, client education on VL testing and screening for eligibility was intensified; clinic flow will continue to be optimized; and ongoing capacity building for clinical providers will be undertaken • Poor documentation on the master cards and HVL registers. Continued supervision and mentorship by site supervisors, Coordinators and CHPOs to ensure VL focal persons are identifying and documenting all HVL clients' results daily. Client with HVL are flagged and documented for long term follow-up by CHWs. • Inconsistent growth monitoring of children and adolescents leads to delayed dose adjustments and chronically low levels of ART which lead to resistance. Mentorship on weight monitoring for all children on ART and engaging guardians to ensure children come to all clinic appointments and are proactive about height and weight assessments will facilitate timely dosing adjustments. |
| Mulanje | <ul style="list-style-type: none"> • Inadequate ART providers to manage ICAC clients and lack of sufficient trained ART second line prescribers in the district, leading to delays in client switch to 2nd line regimen. Tingathe clinician continue to provide on job training and mentorship to MOH providers during ICACs. The program engaged an additional ART nurse at DHO to support ICAC alongside MOH clinicians. |

| District | Viral Suppression challenges and responses |
|----------|--|
| Mangochi | <ul style="list-style-type: none"> • Backlog of VL tests that caused a delay in completing the HVL cascade and switching of clients to second line. Mangochi will be connected to the LIMs system in July which should facilitate faster results delivery and reduce time that samples spend in lab. • Improvements in the HVL cascade management, particularly among children, led to a short supply of second line regimens. Tingathe worked with district pharmacist to redistribute available stocks and procure a larger order to assure availability moving forward. • Inadequate staff to manage ICAC clinics at DHO. Baylor provided one additional ART nurse who is based at the District hospital to manage ICAC clinics together with MoH clinician. • EMR not capturing viral load information and the master card does not really show when the client was bled for VL hence missing clients due for VL in EMR sites. Beyond data entry, the EMR should be programmed to be more responsive to program needs for improved patient care e.g. provide lists of clients due for viral load for appointment booked on a particular day. |
| Machinga | <ul style="list-style-type: none"> • Untrained ART providers in Machinga are resistant to establishment of ICAC clinics. CPD sessions were held in a few clinics to introduce the concept and motivate them for the establishment of these clinic days. The expectation of financial incentive to support ICAC remains a barrier that teams continue to negotiate with DHMT members and facility staff. • Some clients with HVL are missed during IAC sessions. The Research Fellow based in Machinga is developing a short video of an IAC session to overcome poor quality IAC sessions and shortage of staff. The video will be used to provide IAC during busy ART clinics. |
| Balaka | <ul style="list-style-type: none"> • Few ART second line prescribers in the district results in delays in switch to 2nd line. Tingathe coordinators switch clients in sites where there is no 2nd line prescriber. • Lack of trained ART providers due to staff turnover. Untrained providers are mentored and supported with job aids to provide ART |
| Phalombe | <ul style="list-style-type: none"> • Inadequate attention is paid to clients with TB attending the ART clinics. HIV clients with TB are now being enrolled into ICAC clinics • No active screening for TB patients in ART clinics in the facilities. Supervision and mentorship to CHWs will be intensified. |

Viral Suppression activities in the next quarter

| District | Viral Suppression activities in the next quarter |
|---------------|---|
| All districts | <ul style="list-style-type: none"> • Assign a CHW in each site to conduct thorough screening of clients due for VL by checking each patient's master card during ART clinic; flagging of master cards of clients eligible for VL • Ensure clinic flow is optimized; where it is not, change client /patient flow to allow for VL samples to be drawn prior to seeing clinicians and before ARV refills. • Quarterly viral load audits of the full cascade will continue at all sites and teen clubs as a tool to identify gaps in viral load cascade • Introduction of a new monthly viral load audit tool, the site supervisor high viral load (HVL) checklist to identify barriers and gaps in the cascade and link to immediate reparative action. |

| District | Viral Suppression activities in the next quarter |
|----------|--|
| | <ul style="list-style-type: none"> • Mentorship on management of HVL and 2nd line clients to ART providers with coordinators performing regimen switches at facilities without a second-line provider. • Supervise focal persons and site supervisors to ensure all clients with HVL are assigned to a CHW, documented on a CHW tracing form, followed up, receive IAC, a second VL draw and scheduling for the next available ICAC clinic for switching • Continue to provide support to labs processing viral loads, in particular to Balaka Dream, Queens and KCH. |
| Mulanje | <ul style="list-style-type: none"> • Conduct quarterly VL audit at all sites and at teen clubs • Assign a CHW to screen clients due for VL by checking each patient's health passport during ART clinics. • Monitor the client /patient flow to allow clients have their VL samples drawn prior to seeing clinicians and before ARV refills • Flag master cards whose clients are due for VL • Ensure all clients with high VL are booked for ICAC and are entered in appointment register. • Address VL gaps during SS, HDAs and CHWs review meetings |
| Mangochi | <ul style="list-style-type: none"> • Mentorship on management of HVL and 2nd line clients to ART providers. • Continue ICAC clinics |
| Balaka | <ul style="list-style-type: none"> • Monthly viral load audits will help to monitor gaps and work on them. • Onsite orientation of providers who were not trained in the current ART guidelines on the milestones for VL sample collection |
| Phalombe | <ul style="list-style-type: none"> • Introduction of ICAC to sites |
| Salima | <ul style="list-style-type: none"> • Introduction of ICAC to sites • Intensify follow up of all HVL patients |

SO 9 - Strengthen TB management: Implementation progress

| SO # | SO | Explanation |
|------|--------------------------|---|
| 9 | Strengthen TB management | Strengthen TB screening, prevention, diagnosis and treatment among PLHIV and IPT prescription for >=90% eligible clients including IPT delivery |

Tingathe supports TB intensified case finding, diagnosis, linkage to care and treatment in all supported sites. Tingathe offered PITC to TB clients in the TB wards and TB clinics, and TB screening to all HIV positive clients. During the reporting period, Tingathe achieved over 97% HIV testing coverage among registered TB clients in TB clinic as shown in the figure below.

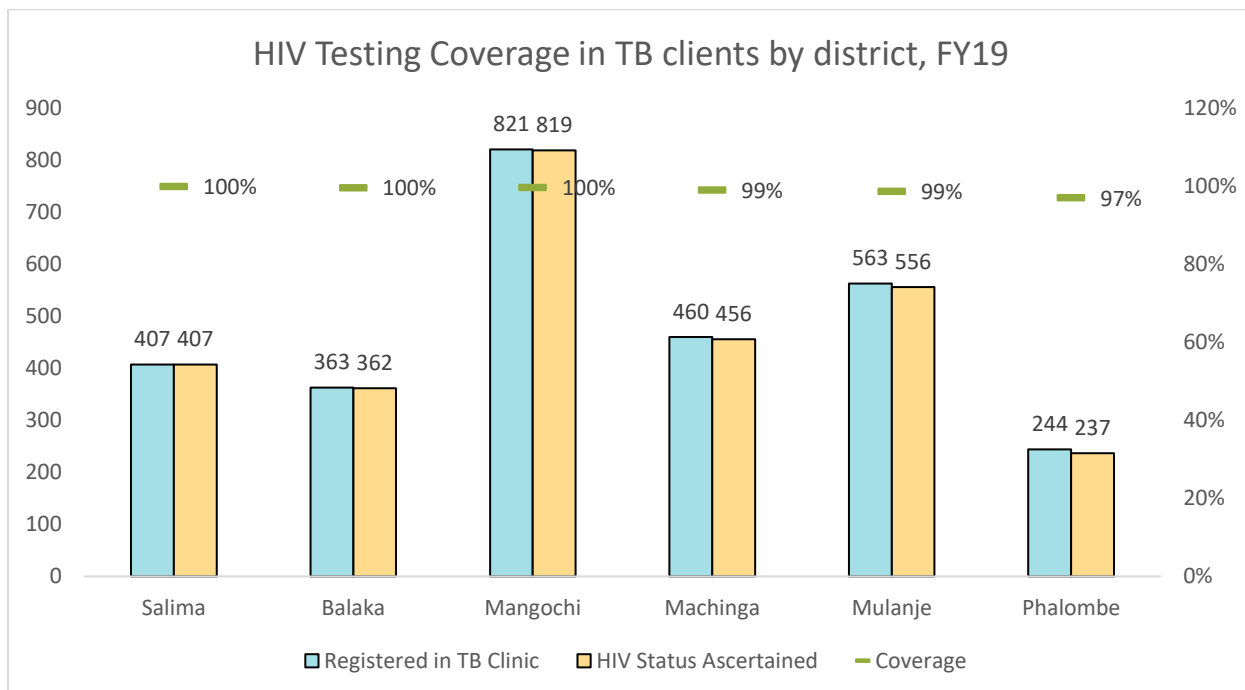


Figure 21: Tingathe HIV testing coverage in TB patents FY19

CHWs provide health education on importance of HIV testing in TB patients and TB screening at ART clinic to raise client awareness on the symptoms and treatment of TB. Tingathe clinicians aid in TB diagnosis during ward rounds and provide mentorship to health workers. Presumptive TB registers were placed at ART clinics to ensure documentation and follow-up of presumptive TB cases.

Clients from Baylor COE with high clinical suspicion of disseminated and extra-pulmonary TB are referred for FASH ultrasound (Focused Assessment with Sonography for HIV-associated TB). District hospitals and some CHAM facilities in all supported districts conduct sputum testing for HIV infected clients with suspected TB using GeneXpert according to the NTP algorithm. Tingathe supported sites send sputum samples to district hospitals for testing.

Strengthen TB management: challenges and responses

| District | TB management: challenges and responses |
|---------------|---|
| All districts | <ul style="list-style-type: none"> • Long turn-around time of results and delays in diagnosis at sites which refer sputum for testing using GeneXpert machines. To address this, district laboratories send sputum positive results within 24hours to enable these clients to be started on treatment as soon as possible. • Insufficient knowledge and skills in diagnosing paediatric TB among some providers. Tingathe coordinators continue with mentorship to ART providers on management of TB and provide continuous professional development on paediatric TB management. • Poor adherence to isoniazid preventative therapy (IPT) due to lack of a fixed dose formulation of IPT/CPT/B6, which causes a high pill burden for clients. CHWs counsel clients to ensure they understand the benefits of IPT and can make an informed decision about whether or not to take the medication. |

Strengthen TB management: Activities in the next quarter

| District | TB management: Activities in the next quarter |
|---------------|---|
| All districts | <ul style="list-style-type: none"> Continue to promote the establishment of TB infection, prevention and control bodies with dedicated focal persons in order to address gaps at facilities. Continue to focus mentorship and ensure quality TB screening of all clients starting ART, particularly important during the DTG transition, to prevent TB immune reconstitution inflammatory syndrome. |

Health Systems Strengthening

| SO # | SO | Explanation |
|------|---------------------------------------|---|
| 12 | Quality assurance/quality improvement | Strengthen national, district, and site level quality assurance and improvement systems |

SO 12 - Quality assurance/quality improvement: Implementation progress

Tingathe implemented continuous quality improvement efforts in all supported sites. Facility staff identified gaps through site assessments, mentorship, SIMS and review of site level performance data. They complete site-specific quality improvement plans with clear gaps and action plans for addressing the identified gaps.

ART & HTS performance review meetings organised by Tingathe reviewed program performance for supported sites in 7 districts. Tingathe and MOH staff work together to identify challenges and propose solutions; for example, during one such meeting in Mulanje district, Tingathe team and MOH representatives discussed strategies to improve ART linkage indicators and early infant diagnosis at all supported sites following sub-optimal performance of the sites from Semi-annual data, and the District ART Coordinator agreed to address the issue of inadequate 2nd line ART providers in the district and establishment of MIP clinics.

All the Tingathe supported sites implemented HTS using the national approved algorithm. To ensure that quality test kits were used, quality controls were run for each new batch of kits used or once a week for low volume sites. HTS providers underwent proficiency testing semiannually to evaluate their testing skills.

Tingathe Coordinators and CHPOs continued to provide Clinical and systems strengthening mentorship to MOH ART providers and facility-based program staff at sites in 7 districts. All sites continued to monitor and log needed improvements using the Continuous Quality Improvement form. Coordinator and CHPOs check progress at each site visit and discuss with site staff to identify root causes, plans are developed to address challenges/ gaps within a reasonable timeframe. The forms are kept in the site binder to enable a continuous review process of action achievements. Larger or longer term CQI projects are discussed and designed with site level CQI committees.

Exemplary Quality Improvement Projects

QI Project 1: *CHW follow-up of all clients who had not started ART using new tracing tool, Katema HF, Mangochi*

Problem: Suboptimal linkage to care

Progress: Implemented in Q3, facility linkage in April identified 19 clients and only linked 16 (84%). In May identified 14 clients and linked 12 (86%). June identified 14 and linked 15 (107%)

Action: Assigned ART provider during the outreach clinic to initiate clients found positive to assure linkage

QI Project 2: *30% program testing should be based on ICT strategies, Mangochi*

Problem: Suboptimal screening of index clients for ICT (contributing to low percentage of new positives identified through ICT)

Progress: Implementation ongoing at 12 sites in Mangochi. Only 2% all new positives were identified through ICT strategies at the start of this QI project. Each site identified several interventions to improve screening of index clients. Interventions included offering ICT services and follow up for contacts testing the Plan-Do-Study-Act (PDSA) cycle approach to modify interventions and monitor progress.

Results demonstrated the following;

- Percentage of testing increased by 229% from 285 before Interventions in April and May to 937 post interventions in June and July 2019.
- Number of untested contacts increased by 122% from 730 to 1,624.
- Number of clients offered active referrals increased by 249% from 206 to 514 (Contract Referral by 103% from 127 to 258, Provider Referral by 262% from 50 to 181, Dual Referral by 159% from 29 to 75)
- Tracing for ICT increased by 233% from 144 to 1,490
- Number of Positives Identified increased by 179% from 29 to 79
- Number of men tested increased by 203% from 67 to 203 (positives by 94% from 18 to 35)
- Number of Females tested increased by 202% from 60 to 181(positives by 300% from 6 to 24)
- Children tested also increased by 266% from 158 to 578(positives by 425% from 4 to 21).

Planned actions: This intervention will be rolled out to the next 12 under performing sites. ICT community follow up will be done by community partner (One Community) in any selected facilities where there is a program overlap.

HSS challenges and responses

| District | HSS challenges and responses |
|---------------|--|
| All Districts | <ul style="list-style-type: none"> • Few MoH staff trained on the New ART guidelines – this has a huge impact in the scale up of some innovative strategies and implementation of new changes following the new ART guidelines including TLD (DTG regimen) transition. To address this Baylor supported 2 ART review meetings – early April and June, where the trained ART mentors led by ART coordinator oriented the staff on the major changes in ART program implementation (care and treatment) |

| District | HSS challenges and responses |
|----------|--|
| Mulanje | <ul style="list-style-type: none"> • Inadequate space for health service provision. In consultation with MOH, Tingathe provided temporary tent spaces to address this problem • Inconsistent availability of Paediatric 2nd line drugs for newly diagnosed pediatric clients (failing on first line). Tingathe lobbied for availability of buffer stocks of 2ndline ART drugs to be kept at District Pharmacy and be used as one month ART supply to new 2ndline paediatric clients while waiting for the normal supply of drugs from HIV logistics. HIV logistics has since responded and facilities supplied in q4. |
| Mangochi | <ul style="list-style-type: none"> • Despite providing monthly calendars and monthly funding for Ministry Supervisory visits for each zone, few MOH providers actually joined Tingathe mentors to visit sites in FY19. The team met with the ART coordinator who has agreed to pre-schedule visits in the coming months. • Despite support for QI meetings at the site level, QI teams are not meeting regularly. Non-Baylor staff perceive QI to be a Baylor initiated activity and have not readily engaged despite the fact that QI teams and projects are MoH mandated. Tingathe will include the Quality Improvement Coordinator in the MOH supervision team to the zones. • Challenges negotiating with MOH infrastructure department; refusal to allow tents or dropboxes. Continued negotiation with district is ongoing and if unable to resolve issues will be forced to relocate infrastructure support to other districts. |
| Machinga | <ul style="list-style-type: none"> • MOH knowledge gaps in new ART guidelines Tingathe Organised CPD sessions at selected facilities (including DHO, Ntaja) where the teams were oriented to DSD ART models of care. This included rationale for the respective DSD model, target group, referral criteria, M&E data synthesis • MoH staff not taking ownership of the HIV programming at site <ul style="list-style-type: none"> - Tingathe supports MoH supported site visits. – The HTS and ART coordinator joined the Baylor team for joint mentorship and supervision. - Engage additional MoH mentors - Encourage ART and HTS coordinators to lead program related sessions during district review meetings and ART focal persons to lead the CPD sessions at facility level with support of the program coordinator. • Incorrect data on cohort size leading to frequent need for stock relocations • Supported the MoH Baobab ART cohort data cleaning exercise at select sites; accurate cohort numbers allow proper justification for ART commodities. |
| Phalombe | <ul style="list-style-type: none"> • Inadequate space for health service provision. In consultation with MOH, Tingathe will provide temporary tent spaces to address this problem |
| Balaka | <ul style="list-style-type: none"> • Transport challenges due to 1 vehicle for the district (14 facilities); frequent coordination with Lilongwe office and Machinga offices to provide support where possible to this sustained district. • Frequent MOH staff turnover: continued mentorship and planned CPDs to orient new providers on ART and relevant program interventions |

HSS activities in the next quarter

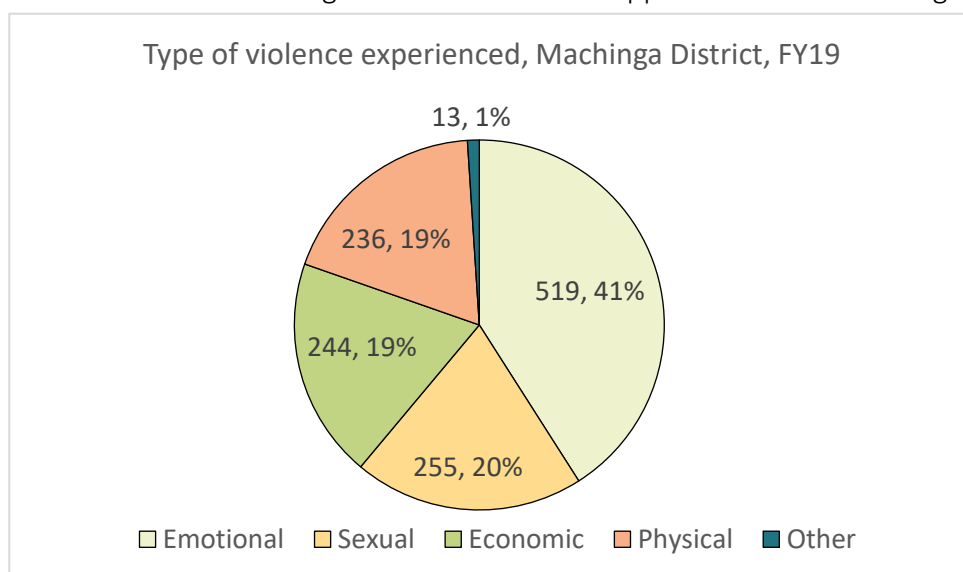
| District | HSS activities in the next quarter |
|---------------|---|
| All districts | <ul style="list-style-type: none"> • Conduct feedback loop meetings to enable facilities plan on how to improve performance toward targets • Conduct ART and facility review meetings to review performance and with MOH counterparts identify next steps to improve HIV care. • Continue data collection and cleaning exercise (complete exercise in 4 priority districts by end of Q4; Balaka and Salima by end of FY20 Q1) to establish clear baseline for TX_Curr • Intensify site supervisors' supervision by implementing SS checklists |
| Mulanje | <ul style="list-style-type: none"> • Involve QI committees in facility level performance review meetings • Joint supervision with ART, HTS, PMTCT, TB, Cervical Cancer Coordinators. • Support MoH on supply chain management to make sure that HIVST kits are available in all sites |
| Mangochi | <ul style="list-style-type: none"> • Pre-scheduled MoH supervisory visits will be made regularly in all zones by both HTS and ART teams to provide QI support and guidance, especially to poorly performing sites. • Assess number of patients and their regimes at each facility quarterly to forecast the supply needed from the HIV Unit to avoid unnecessary stock outs |
| Machinga | <ul style="list-style-type: none"> • Conduct needs assessment and supply selected facilities with tents to provide additional space for HTS, ICT counselling |
| Phalombe | <ul style="list-style-type: none"> • Conduct needs assessment and supply selected facilities with tents to provide additional space for HTS, ICT counselling • Renovate of testing rooms at Mwanga, Mkhwayi, Nambazo, Nkhulambe • Continue supporting relocation of second line drugs in the district. • Plan for joint mentorship and supervision with support from ACCORD. |
| Salima | <ul style="list-style-type: none"> • To continue with data driven mentorship/ system to less performing sites |
| Balaka | <ul style="list-style-type: none"> • Optimize usage of district WhatsApp group to follow performance |

Prevention

| SO # | SO | Explanation |
|------|-----|---|
| | GBV | Support facility-based GBV services in Machinga |

SO GBV: Implementation progress

Tingathe is implementing facility-based care of survivors of gender-based violence (GBV) services at 11 selected health facilities in Machinga district. In FY 19, a total number of 891 clients received the minimum package for survivors of GBV, 161 % of the annual target. There was a tremendous increase (95%) in the number of clients accessing GBV services at all supported sites in Machinga in Q3 compared to previous periods (18 cases in Q2 to 383 cases in Q3). Majority of GBV cases seen in FY19 were due to emotional violence (41%) followed by sexual violence (20%), physical and economic violence at 19% each.



Tingathe implemented a number of interventions that led to improvement in the number of cases served which are outlined below.

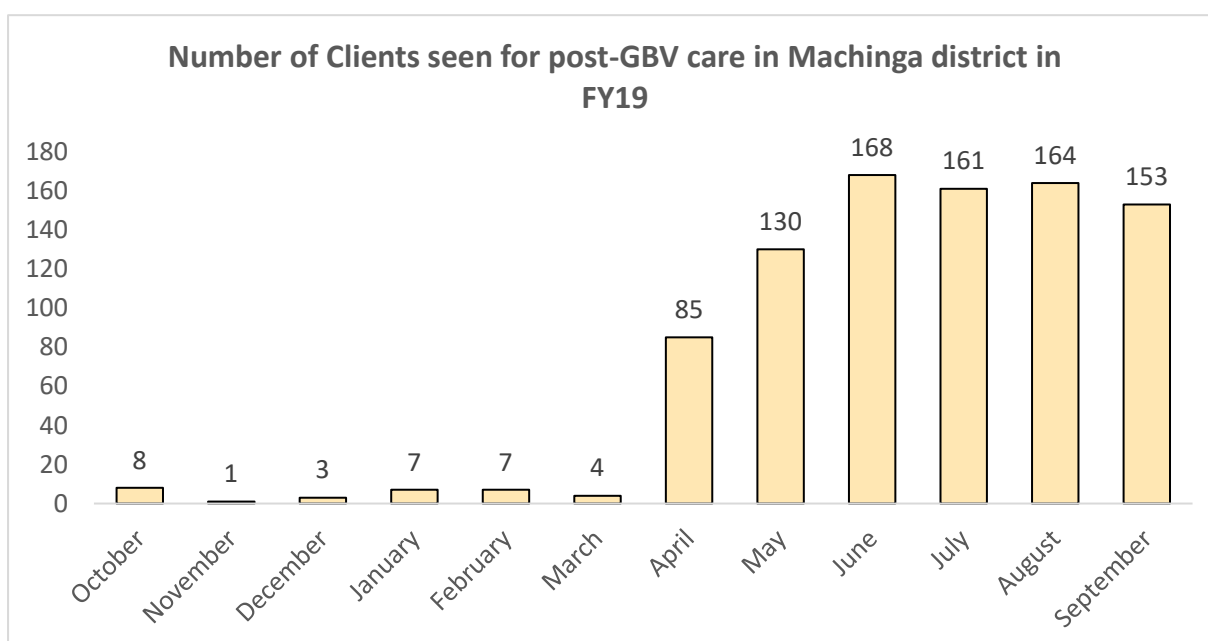


Figure 23: Number of GBV survivors reached with minimum package of services, Machinga District in FY19

Tingathe began implementation of GBV services at 6 facilities in October 2018, and scaled up to 5 more sites in April 2019 increasing the total number of supported sites to 11 by end of FY19. All the targeted sites were assessed to identify gaps in the current GBV service delivery to inform planning for implementation. Tingathe conducted two trainings and site level orientations where 22 clinical staff were trained on the role of the health system in the response to GBV and 32 CHWs were trained to support survivors of GBV. Community mobilization meetings were conducted involving local community leaders such as chiefs, religious leaders, Victim Support Units, local organizations, and social welfare departments. The meetings focused on creating demand for GBV services provided by health facilities.

In order to improve GBV services, Tingathe identified a district GBV focal nurse for Machinga district who conducted monthly supervisory visits to GBV sites. A supervision checklist was developed to identify and rectify gaps hindering seamless service provision. The GBV focal person mentored and supervised health care providers on case identification and provision of a minimum package of GBV services which include screening and referral of complex cases to specialized care services. The focal person ensured proper documentation and reporting was done by all targeted sites to track progress in these facilities and WhatsApp reporting was as a tool for communication. Tingathe intensified Partner collaboration through regular communication to ensure the continued care to survivors of GBV to access our minimum package of care.

GBV challenges and responses

- Attrition of staff trained in GBV care; 3 MOH staff were transferred, while others have resigned. To address capacity gaps created as a result of trained staff attrition, the program will orient new staff to offer the minimum package to GBV services to survivors, and conduct ongoing supervision to sites to identify and resolve gaps.
- Stock outs of drugs to offer minimum package of GBV services. There is ongoing advocacy with DHO for adequate supply of drugs to stop service disruption.
- Corrupt practices by law enforcement referral partners that inhibit or undermine the comprehensive response of GBV services.

GBV activities in the next quarter

- Hold meeting with DHMT to advocate for availability of essential drugs, post exposure prophylaxis (PEP), emergency contraception and trained personnel
- Source IEC materials on GBV services for client education.
- Hold coordination meetings with other implementing partners to improve efficiency and continuum of care
- Train additional service providers to address the gaps created by attrition and transfers.

Cervical Cancer

In FY19, Tingathe program began to support Ministry of Health in scaling up of cervical cancer services across 9 sites in Balaka, Mulanje, Machinga, Mangochi, Salima and Phalombe Districts targeting women living with HIV. The program integrates cervical cancer services with ART services as well as strengthening existing systems and structures for effective service delivery. From October 2018 to September 2019, 10,763 HIV positive women were screened for cervical cancer representing 113% (10,763 / 9,545) achievement of annual target. Of the 462 HIV+ clients found VIA+, 290 (63%) received same-day treatment. The remaining 172 women were either referred for various clinical reasons or refused treatment service. This is depicted in the graph below.

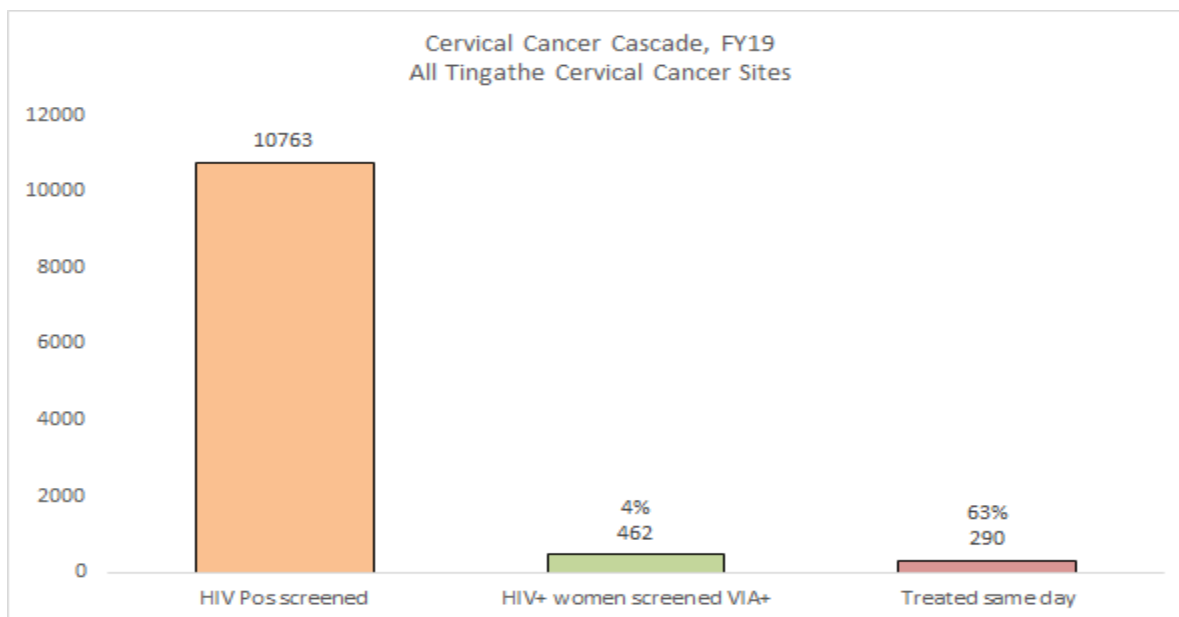


Figure 24: Tingathe Cervical Cancer Cascade, FY19

In July 2019, Tingathe started collecting disaggregated data on VIA+ clients not treated the same day. Data from prior periods did not define the numbers referred for other services and those who refused. The quarter 4 cascade below is developed using disaggregated data.

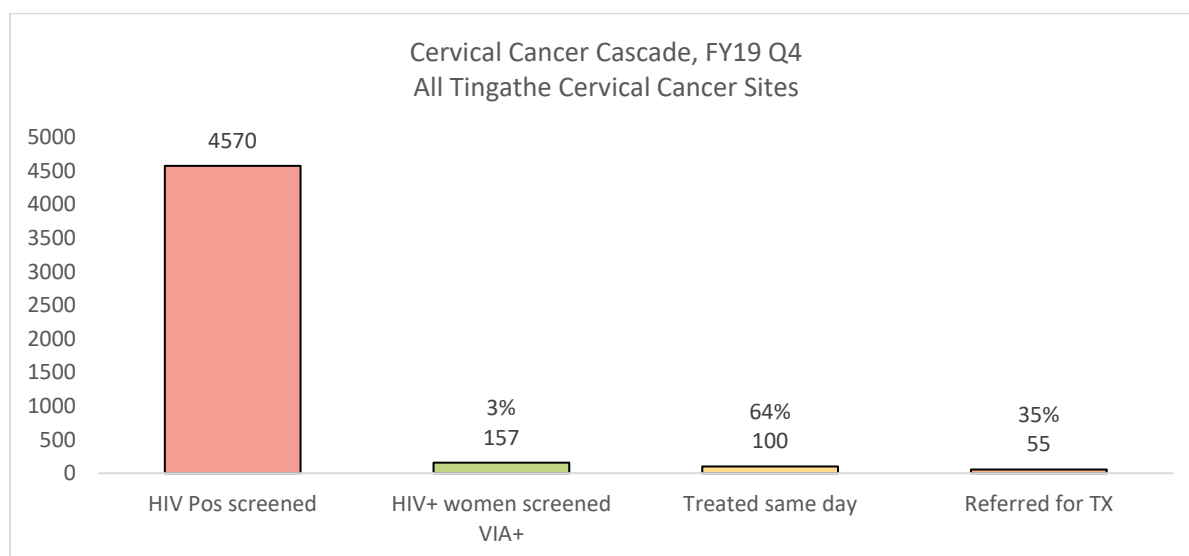


Figure 25: Cervical Cancer Cascade, disaggregated data -Q4

The number of Women Living with HIV(WLHIV) screened for cervical cancer increased over the course of the year with Q4 registering the highest number, 4 570 (42% of annual screening).

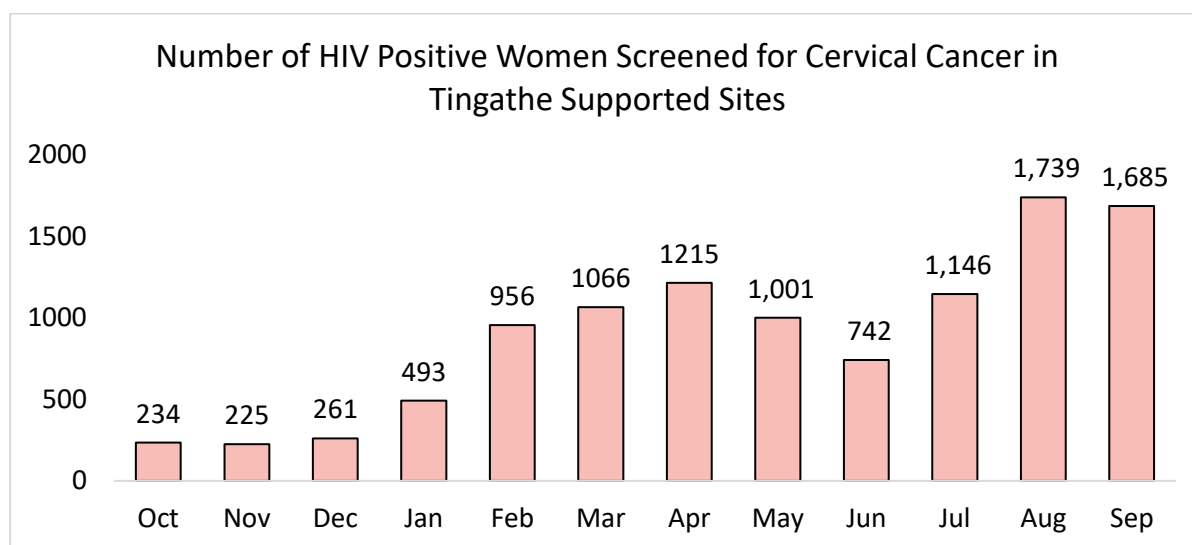


Figure 26: Number of women living with HIV screened for cervical cancer – FY19

The Tingathe program exceeded its annual target for cervical cancer screening at 113% (10,763 / 9,545) in FY19. This is attributed to good performance by each of the targeted sites except for 2 Christian Health Association of Malawi (CHAM) sites in Mulanje district; Mulanje Mission Hospital and Namasalima Health Centre. The two sites do not have a dedicated cervical cancer nurse. Tingathe compensated nurses who worked extra hours/days to provide cervical cancer services five days a week.

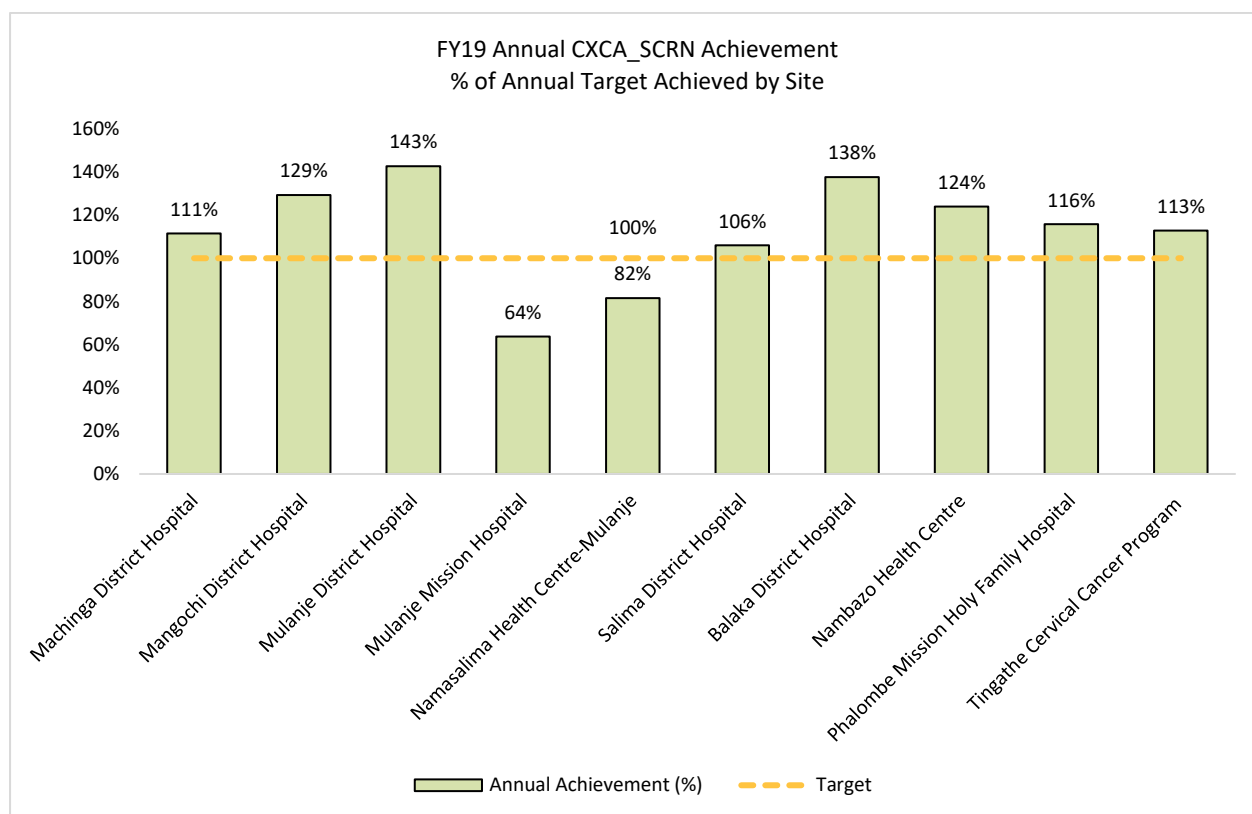


Figure 27: Site level achievement of cervical cancer screening -FY19

Cervical Cancer: Implementation progress

In FY19, Tingathe focused on improving VIA screening and treatment of precancerous lesions including filling the gaps identified during site assessments. Tingathe employed and seconded 7 Cervical Cancer nurses at high volume sites in Balaka(1), Phalombe (2), Salima(1), Mulanje (1), Machinga(1)and Mangochi (1) districts which increased number of VIA screening days from one or two to five days a week. Linkage of women from ART to VIA clinics at these sites improved tremendously. Three of the cervical cancer nurses were recruited in January whilst four were hired in June hence high numbers in Q4. VIA providers and CHWs raised awareness for Cervical Cancer screening services through health education at the facility ART clinic and community sensitisation events with local leaders and WLHIV groups, demand for the VIA service increased.

During this reporting period, Tingathe trained 16 new and 84 old VIA providers at the 9 targeted sites to enhance capacity in VIA service provision. Supervision and mentorship was done by national trainers to these sites which it instilled confidence in both newly-trained and old VIA providers in screening and treating VIA clients. In addition to regular supervision, Tingathe implemented Mass Cervical Cancer Screening Mentorship Weeks at Holy Family Mission and Nambazo Health Center in Phalombe, Machinga DHO, Mangochi DHO and Salima DHO. These week long screening weeks improved the clinical skill of VIA providers through increased exposure to more screening under supervision of MOH Master Trainers. Community mobilization and intensive health talks at the facility's ART clinics preceded the screening mentorship week allowing more women including WLHIV to access VIA screening and thermo coagulation treatment services. A library of cervical images on cards were used at a beginning and end of the week to assess knowledge and accuracy of mentees learning.

The program engaged services of a visiting gynecologist on a monthly basis for management of clients with large lesions as well as those suspected. The specialist visits four sites to provide of cancer that were previously being referred to central hospitals for management of large lesions and suspect Cancer at 4 targeted sites. The gynecologist provides Loop Electrosurgical Excision Procedure (LEEP) using LEEP machine supplied by DHA at Salima DHO, Mulanje DHO, Machinga DHO and Mangochi DHO. She collects biopsies, and is in the process of training MOH staff to conduct LEEP themselves. The biopsies are then transported to the UNC histopathology lab at Kamuzu Central Hospital, Lilongwe.

Tingathe supported cervical cancer review meetings in Machinga, Salima, Balaka, Phalombe, Mulanje and Mangochi. These meetings improved coordination of VIA services in the districts and provided a platform for addressing challenges affecting implementation of the program. Challenges and solutions on issues such as documentation in VIA register, linkage of ART clients to VIA clinic, and mechanism for following up of clients with VIA Positive and suspect cancer were discussed.

Cervical Cancer challenges and responses

1. Tingathe experienced challenges in rolling out the program at Salima DHO, Mangochi DHO, Holy Family Mission hospital and Mulanje mission hospital. Salima straggled due to lack of commitment on the part of MOH providers and had a very tiny room for VIA services. Tingathe seconded a full time CHN and lobbied for a better room for VIA services which is currently in use. Holy family and Mulanje mission wanted women to pay for the services. Tingathe successfully advocated for free services for all women at these two facilities. Holy Family accepted to have a CHN and to benefit from MoH supportive supervision and mentorship. Mulanje Mission signed a MOU with Baylor to allow daily screening by off duty VIA trained nurses from Mulanje Mission in September and since had had a significant improvement in screening services. Mangochi DHO also had challenges in identifying a suitable space for VIA services after fire gutted part of the facility, however Tingathe successfully negotiated with DHMT to provide a conducive room for VIA services currently in use.
2. Staff turnover: two CHNs that were hired for Salima and Machinga DHOs resigned. Tingathe hired a new CHN for Salima and is yet to replace the nurse for Machinga district.
3. There has been a low turn-out of women to access VIA services at some sites. Tingathe implemented cervical cancer screening weeks to sites such as Nambazo and Holy Family in Phalombe district and Namasalima in Mulanje district which enabled more women to be screened.
4. A limited number of VIA providers at some sites affects program performance. Tingathe recruited cervical cancer screening nurses to oversee program implementation at sites including Salima District Hospital, as well as Nambazo and Holy Family Hospital (both in Phalombe district).

Cervical Cancer activities in the next quarter

1. Deployment of cervical cancer nurses to Machinga district Hospital to allow for full time service provision
2. Conduct continuous monitoring and mentorship for VIA providers in all the Baylor supported districts

Environmental Mitigation and Monitoring

During this reporting period, USAID approved Environmental Mitigation and Monitoring Plan (EMMP) which was submitted in compliance with the provisions of this award. The EMMP described plans designed into the project for incorporating and monitoring appropriate mitigation measures particularly in regards to construction and waste disposal/infection prevention and control.

Monitoring and Evaluation

Tingathe is committed to continuous quality improvement using routine program data and operational research. The M&E team provides supportive supervision and mentoring to all sites and ensure accurate and complete documentation in all registers and program tools. To ensure data quality, site reports are verified for consistency with source documents before data entry. Data quality is discussed during monthly site-level data review meetings, and solutions agreed upon with both Tingathe and MOH counterparts.

Tingathe implemented additional activities to promote data quality as follows; MOH report-writing trainings at three sites in Machinga in quarter two, worked with MOH facility staff to strengthen report-writing before the MOH supervision team visit, conducted a data alignment exercise to document and explain discrepancies between Tingathe and MOH data and identify areas for improvement.

In FY19, Tingathe worked closely with the Ministry of Health and CDC HIS Partner in expanding the EMRS in Malawi. The program supports 63 sites with Point of Care (POC) EMR deployed by Baobab Health Trust, and 56 eMasterCard sites deployed by EGPAF. The HIS partner transitioned from Baobab Health Trust in FY19 to EGPAF in FY20. Tingathe has been collaborating with EGPAF, MOH, and PEPFAR during this period of transition.

Tingathe has been working closely with site staff to build capacity in data cleaning and quality reviews of the POC EMR systems. In addition, the M&E team has been conducting a TX_CURR DQA to ensure quality of data at eMastercard sites. Throughout the transition period, Tingathe site staff and M&E team have been communicating regularly with EGPAF District Officer to report challenges and work together to address any issues.

The following were notable challenges encountered during data collection:

- Frequent downtime in many sites of POC EMR systems due to failure of backup power supply, or site power outages lasting over 12 hour created a backlog of data entry. Additionally, software updates in Q4 2019 prior to EMR system handover led to slow system function and in some cases inability to produce DHA supervision cohort reports. All issues with EMR were reported to the HIS partner district level contact persons.
- Total number of clients alive on ART in the registers did not always align with data in facility report due to double counting or incorrect page summations in the registers. Where discrepancies were noted, the Tingathe M&E team and coordinators discussed with the site in-charge to rectify the reporting issue. Additionally, sites where reporting challenges were noted will continue to receive enhanced mentorship by the M&E team to improve documentation and reporting.
- Tingathe experienced challenges in accessing HTS data from community outreaches conducted by implementing partner One Community's during the disaggregated data collection exercise despite prior communication of the IP. However, other partners' data (such as PSI and Banja la Mtsogolo) was accessible.

Operational Research

Ongoing research projects

Tingathe had the following research projects in operation in FY19;

- a. Kim MH, Mazenga AC, Zomba G, Abrams EJ, Chinkhumba J, Ahmed S, Kazembe PN. **VITAL Start (Video Intervention to Inspire Treatment Adherence for Life) – supported through an external funding stream.**

Description and Progress: Tingathe developed an innovative 35-minute, single session counselling video aimed at standardizing pre-ART education and promoting behavior change using pre-tested messages woven into an entertaining drama. The video promotes partner involvement, maternal initiation and retention on ART by providing an intervention at the critical teachable moment between testing HIV-positive and committing to life-long ART. To understand more fully how VITAL Start compares to the standard of pre-ART counselling currently being done at health facilities, Tingathe is conducting a formal evaluation of VITAL Start and examining impact on partner outcomes, and maternal ART adherence. The study started on 20th September 2018 and by end of September 2019, a total of 377 women against a study sample of 704 participants were enrolled across the three sites in Mangochi (Mangochi DHO) and Lilongwe (Kawale and Area 25 Health Centres). There is good collaboration with all stakeholders present at the facilities.

- b. Buono N, Worku A, Kasola J, Ng'ona K, Mitambo C, Auld A, Goldstein R, Nyangulu M, Odek J, Kim E, Wadonda-Kabondo N, Maida A, Shiraishi R, Valverde E. **Assessing the Effectiveness and Feasibility of Voluntary Assisted Partner Notification Services in High HIV Burden Districts of Malawi: a Pragmatic, Non-Randomized Stepped-Wedge Study.**

Description and Progress: The main aim of this study is to evaluate the effectiveness of Voluntary Assisted Partner Notification (VAPN) in real-world programmatic settings; a non-randomized, stepped wedge study in high volume facilities in 6 high HIV burden focus districts (Blantyre, Zomba, Chikwawa, Machinga, Mangochi and Lilongwe urban). The primary objective is to compare the percentage of contacts tested during the standard of care (SOC) phase (i.e., using FRS index testing methodology) with the percentage of contacts tested during the SOC plus VAPN phase, by 1, 2, and 3 months after the initial contact with the index client. The study was approved on 5 Feb 2018 by the National Health Sciences Research Committee (Malawi) and on 8 Nov 2018 by Baylor College of Medicine IRB (USA).

Baylor-supported sites in Mangochi (Koche and Mangochi District Hospital) and Machinga (Ngokwe, Nsanama, Ntaja, Machinga District Hospital) commenced study recruitment in November and December 2018 respectively. The study was closed in August 2019, because VAPN was approved by the Malawi MOH as part of routine HIV testing services in March 2019. While the study was being conducted, 865 participants were enrolled. Based on our knowledge of adverse events for this study, there has been no significant increase in risks to participants. There has been no event that required reporting to the IRB as an anticipated problem. The conduct of the study was being overseen by MOH, CDC and USAID

Articles published in FY19;

1. Tembo TA, Kim MH, Simon KR, Ahmed S, Beyene T, Wetzel E, Machika M, Chikoti C, Kammera W, Chibowa H, Nkhono Z, Kavita E, Kazembe PN, Rosenberg, NE. Enhancing an HIV index case testing passive referral model through a behavioral skills-building training for healthcare providers: a pre-/post-assessment in Mangochi District, Malawi. *J Int AIDS Soc.* 2019; 22(Suppl 3):e25292. PMCID: PMC6639699. doi:10.1002/jia2.25292.
2. Penazzato M, Townsend CL, Rakhmanina N, Cheng Y, Archary M, Cressey TR, Kim MH, Musiime V, Turkova A, Ruel TD, Rabie H, Sugandhi N, Rojo P, Doherty M, Abrams EJ. Prioritising the most needed paediatric antiretroviral formulations: the PAD04 list. *Lancet HIV* 2019; 6: e623-31. doi: [10.1016/S2352-3018\(19\)30193-6](https://doi.org/10.1016/S2352-3018(19)30193-6)
3. Kim MH, Mazenga AC, Yu X, Simon K, Nyasulu P, Kazembe PN, et al. (2019) Factors associated with burnout amongst healthcare workers providing HIV care in Malawi. *PLoS ONE* 14(9): e0222638. <https://doi.org/10.1371/journal.pone.0222638>
4. [Kim MH](#), [Ahmed S](#), Tembo T, [Sabelli R](#), [Flick R](#), [Yu X](#) et al. VITAL Start: Video-Based Intervention to Inspire Treatment Adherence for Life-Pilot of a Novel Video-Based Approach to HIV Counseling for Pregnant Women Living with HIV. *AIDS Behav* 2019. <https://doi.org/10.1007/s10461-019-02634-1>.
5. Simon K, Hartig M, Abrams EJ, Wetzel W, Ahmed S, Chester E, Chembezi C, Chavula B, Zinganda S, Kavuta E, Chikoti C, Beyene T, Nkhono Z, Kabwinja A, Nyirenda R, Kazembe PN, Kim MH. The Tingathe Surge: A multi-strategy approach to accelerate HIV case finding in Malawi. In press. *Public Health Action* 2019.
6. Flick R, Simon K, Nyirenda R, Namachapa K, Hosseinipour MC, Schooley A, Kavuta E1, Theu J, Kazembe PN, Ahmed S, Kim MH. The HIV diagnostic assistant—early findings from a novel HIV testing cadre in Malawi. *AIDS* 2019; 33(7): 1215-24. PMID: 31045942. Doi:10.1097/QAD.0000000000002159.

Abstract Presentations in FY19

1. Mazenga AC, Kim MH, Ahmed SA, Mlotha V, Kazembe PN, Moodie R, O'Hare B. The relationship between depressive symptoms and adherence to antiretroviral therapy in adolescents living with HIV. *Oral Presentation, 7th Malawi Mental Health Research and Practice Development Conference Meeting 2019, Blantyre, Malawi. 10th and 11th June 2019.*
2. Kim MH, Mazenga AC, Yu X, Simon K, Nyasulu P, Kazembe PN, Kalua T, Abrams E, Ahmed SA. Factors associated with burnout amongst healthcare workers providing HIV care in Malawi. *Oral Presentation, 7th Malawi Mental Health Research and Practice Development Conference Meeting 2019, Blantyre, Malawi. 10th and 11th June 2019.*
3. Bvumbwe MJ, Dziweni L, Ulaya K, Masambuka M, Kazembe PN. Viral re-suppression in suspected second-line HAART failure in the era of intensive adherence counselling (IAC) sessions at Baylor

Clinical Centre of Excellence Lilongwe, Malawi. *Oral Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*

4. Simon K, Holmes B, Maulidi B, Solanki A, Matupa E, Bvumbwe BJ, Odo M, Kazembe PN, Kim MH. Early results from provision of lopinavir/ritonavir (LPV/r) pellets as part of first and second-line ART regimens for young children in an urban health center in Malawi. *Oral Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*
5. Mazenga AC, Maleta K, Ahmed, Kazembe PN, Kim MH, Moodie R, O'Hare B. The relationship between depressive symptoms and adherence to antiretroviral therapy (ART) in adolescents living with HIV (ALHIV) in Lilongwe and Zomba, Malawi. *Oral Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018*
6. Simon K, Hartig M, Wetzel E, Chester E, Chembezi C, Kabwinja A, Nkhono Z, Kavuta E, Nyirenda R, Kazembe PN, Ahmed S, Kim MH. The surge: a targeted, multi-strategy approach to accelerate HIV case finding in Malawi. *Oral Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*
7. Villiera J, Kamiyango W, Mehta PS, Kazembe PN, El-Mallawany NK. Potential for improved survival outcomes after treatment with intensified chemotherapy and antiretroviral therapy in children with pulmonary Kaposi sarcoma presenting with severe pleural effusions. *Oral Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*
8. Tembo T, Simon K, Ahmed S, Beyene T, Wetzel E, Kabwinja A, Kammera W, Chibowa H, Chavula B, Nkhono Z, Kavuta E, Kazembe PN, Kim. Scale-up of a passive referral model of HIV index case testing to accelerate case identification in Mangochi, Malawi. *Oral Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*
9. Wanda W, Manda G, Mpasa A, Wachepa S, Mtete I, Butia B, Chasela M, Sabantini M, Chirwa G, Bank R, Mulemba T, Itimu S, John T, Wasswa P, Huibers M, Kazembe PN, Martin S. Treatment outcomes of paediatric non-hodgkin lymphoma (NHL) following chemotherapy completion: a single centre experience- Kamuzu Central Hospital (KCH), Malawi. *Oral Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*
10. Wetzel E, Simon K, Beyene T, Turetsky R, Kabwinja A, Kammera W, Chavula B, Chikoti C, Chibowa H, Mhango J, Kazembe PN, Ahmed S, Kim MH. Achieving the second 90: Linking adolescents living with HIV to treatment in rural Malawi in the era of test and treat. *Poster Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*
11. Makoza B, Makuti S, Magalasi P, Mikwamba G, Mafeni C, Katema C, Daire C, McKenney A, Lungu J, Kazembe PN. Evaluating the impact of child HIV disclosure trainings to health care workers in 13 health centers in Malawi. *Oral Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*

12. Manda G, Wanda W, Mpasa A, Wachepa S, Mtete I, Butia M, Chasela M, Mulemba T, Sabantini M, Chirwa G, Bank R, Lemon S, Nandi B, , Huibers M, John T, Wasswa P, Kazembe PN, Martin S. Combination chemotherapy of Wilm's tumour with vincristine, doxorubicin and cyclophosphamide (VDC): challenges and treatment outcomes from a resource limited setting in Lilongwe, Malawi. *Poster Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*
13. Wanda W, Manda G, Mpasa A, Wachepa S, Mtete I, Butia M, Chasela M, Sabantini M, Chirwa G, Bank R, Mulemba T, Itimu S, John T, Wasswa P, Huibers M, Kazembe PN, Martin S, Margolin J. Paediatric chronic myeloid leukaemia in Lilongwe Malawi. *Poster Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*
14. Ng'ambi A, Tembo T, Chavula B, Kavuta E, Kawonga S, Beyene T, Kazembe PN. Increasing HIV testing uptake among key groups through targeted community outreach setting. *Poster Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*
15. Phiri D, Tembo T, Kawonga S, Mbendala B, Kavuta E, Thomson H, Ulambo J, Beyene T, Simon K, Kazembe PN. Voluntary HIV counselling and testing of family members of adults attending Chinsawa support group led to high HIV case identification in Balaka, Malawi. *Poster Presentation, 20th BIPAI Network Meeting, Johannesburg, South Africa, 12th - 16th November 2018.*

Management and Operations

Tingathe maintains strong management and operations systems which include administration, procurement, human resources and financial teams to support program delivery.

Program Operations

Key Procurement in FY 19

- i. Power back up, Furniture and supplies for new offices in 3 new districts; Machinga, Mulanje and Phalombe districts
- ii. Generator and heavy-duty copier for the Machinga office
- iii. A Toyota Land Cruiser to support the cervical cancer Program
- iv. Sixty (60) laptop computers and bags for new staff and replacement of old malfunctioned computers
- v. Furniture and clinical supplies for health facility HTS rooms in the new districts.
- vi. Cervical Cancer supplies, furniture and sundries for all the districts.
- vii. Android Pad Tablets (110) and covers for M&E functions

Human Resources

In FY19, Tingathe continued hiring staff for the new sites in Machinga, Mulanje, and Phalombe and replaced vacant posts in the old districts Balaka, Salima, Mangochi and Lilongwe to ensure vacant positions were filled for seamless program implementation.

Recruitments

The program recruited 576 candidates

- Programs: 500 staff
- M&E: 38 staff
- Research: 11 staff
- Administration: 12 staff
- Finance: 3 staff
- Transport: 12 staff

Attrition

The following numbers of staff separated with the organization in FY 2019. Attrition was main associated with resignations to take up new opportunities for school and work, and terminations.

- Programs: 94 staff
- M&E: 5 staff
- Research: 5 staff
- Administration: 1 staff
- Finance: 6 staff
- Transport: 6 staff

Financial Management

Financial utilization during the period October 1 to September 2019

During the period, Tingathe got timely funding and was able to run the program smoothly and activities were implemented within the planned period.

Success Story

INTENSIFIED CARE ART CLINIC (ICAC) IMPROVES TREATMENT OUTCOME: *THE CASE OF NUNU FROM MANGOCHI DISTRICT, MALAWI*

At only 26 years old, Nunu S. has led a difficult life, having lost four children before they reached the age of two years and losing her first husband to divorce when he learned she was HIV positive. Nunu was chronically ill and repeatedly defaulting from HIV care when a Tingathe CHW found her and her premature newborn baby on the Kangaroo mother care ward in June 2019 and linked her to Intensified Care ART Clinic (ICAC), saving the life of both Nunu and her baby.

The Tingathe program, implemented by Baylor College of Medicine Children's Foundation-Malawi, has been implementing ICAC since 2019. ICAC is a differentiated service delivery model targeting clients who will benefit from intensified clinical care such as new ART initiates, children on ART, clients with TB-HIV coinfection, ART clients with high viral load, and clients on 3rd line ART. The goal of ICAC is to provide these relatively more complex clients with longer clinic visits to facilitate enhanced treatment to address client-specific challenges and curb disease progression. Through ICAC, clients receive treatment and adherence support, identification and management of ARV side effects, treatment of opportunistic infections and support for other emerging issues related to HIV care.

In addition to aiming to improve the quality of care provided to clients, ICAC clinic presents a capacity-building opportunity for MOH staff. During these clinics, a Tingathe clinician or doctor provides on-job training and mentorship to MOH service providers to build their clinical capacity and confidence to manage complex/advanced HIV/AIDS cases. This is done through side by side review of ICAC patients, with the aim to ultimately transition the mentorship role from a Tingathe mentor to a qualified member of the district MOH clinical team who will then lead the process.

Diagnosed at Katuli Health Center in Mangochi district, Nunu was initiated on antiretroviral therapy (ART) in 2013 but stopped taking her medication in an effort to hide her illness from her new spouse upon re-marriage. She did not disclose her status, constant bouts of illness only made their destitute living conditions worse, and the 2 hours' walk to the health facility presented yet another barrier.

In 2018, after several instances of ARV default, Nunu was pregnant with her fifth child and agreed to reinstate ARVs. She had problems tolerating the medication, was poorly adherent and her illness did not abate. Health care workers at the site found her case difficult to manage, without adequate time or clinical knowledge to address the psychosocial and clinical factors affecting her. The baby was born prematurely in June 2019, weighing 1300 grams. She was initiated on Kangaroo mother care but was too weak to breast feed, nonetheless the facility discharged her. Again, she became too sickly and was readmitted back to the hospital's post-natal ward.

Noting her absence from clinic, the community health worker (CHW) assigned to her for follow up, identified Nunu in the ward during routine screening of mothers not tested for HIV. The CHW discussed the importance and benefits of having Nunu's case reviewed at the newly introduced ICAC. She was scheduled for immediate review in the next ICAC where a Tingathe medical doctor alongside the facility MOH clinician transferred her to Mangochi district hospital for assessment and treatment of presumed pulmonary TB, commencing her first trip on a journey to a healthy life. At the District hospital, her TB diagnosis was confirmed, she was started on TB treatment, diagnosed with ART treatment failure, and had her ARVs changed to a more effective second line regimen. The baby was enrolled in the early infant diagnosis (EID) program and infant feeding, testing, and prophylaxis was reviewed with Nunu. On discharge, she was advised to continue attending monthly ICAC for clinical reviews and drugs refills.

Nunu is grateful for the care she received at Katuli: *“I was very sick and had no hope that my child will survive. She was so tiny and I had problems breastfeeding her since I was too sick. I appreciate the health workers at Katuli for having an interest in my condition. I am now healthy and my baby is well. The counselling I get here has encouraged me to continue taking my ARVs and TB drugs so that my child is protected and that I get better health.”*

Three months have passed since Nunu attended the first ICAC. She has tolerated the new medication well, is healthier and happy. She is back on her feet and able to do household chores. Her child is healthy too. She attends monthly ICAC. Her husband, who also tested HIV positive, was linked to ART and they have become one another’s support partner for treatment adherence. The CHW follows up on them closely to provide support and answer any questions they may have.



Nunu and her husband at a recent clinic visit.
Photo courtesy: George Phiri

“I can now eat food cooked by my wife and am happy that the child is healthy. I was afraid she (Nunu) will not survive but with these drugs our marriage too will survive. It was hard for me to do everything on my own, I have been solely fending for the family”, reckons Silaji Nunu’s husband.



Adherence counseling session with Nunu and her Husband in progress. Photo courtesy: George Phiri

Nunu represents one of the many clients accessing quality care through ICAC. Katuli health centre has an estimated 2,346 individuals on ART of whom 76 have been enrolled on ICAC (since commencement of the program in June 2019) as a result of complexities such as high viral load, poor adherence to ART, opportunistic infections and adverse drug side effects among others. Of the 76, 27 have been identified with treatment failure and successfully transitioned to more appropriate ART regimens. CHWs provide ongoing supportive counseling to those newly started on ARVs to ensure early retention on care. On job training and mentorship of MOH staff, coupled with provision of necessary SOPs and job aids, has enabled them to identify and competently manage clients eligible for ICAC thereby improving the quality of care given to patients.

Ms. Faith Kautsi, Katulu health centre in-charge and only medical assistant states, *“It is our sincere hope that these clinics will be sustained and be conducted more often. They are not only beneficial to clients, but we service providers, are also learning a lot and our skills are being improved.”*

Tingathe program continues to scale up intensified care ART clinics across all districts of coverage with a two pronged purpose; to improve treatment outcomes for enrolled clients and build sustained capacity of MOH staff to address complex HIV cases.

Appendices

Appendix 1: Tingathe Custom Indicators (Non-PEPFAR)

| Indicator | Description | Data Source | Quarter one results | Quarter two results | Quarter three results | Quarter four results |
|-------------|---|--|--|---|---|--|
| INPAT_COV | Testing coverage at inpatient wards | Tingathe PITC Registers | Adult Male: 97% Adult Female: 98% Pediatric (>1y): 97% NRU: 99% | Adult Male: 100% Adult Female: 100% Pediatric (>1y): 94% NRU: 100% | Adult Male: 96% Adult Female: 98% Pediatric (>1y): 97% NRU: 100% | Adult Male: 97% Adult Female: 96% Pediatric (>1y): 98% NRU: 87% |
| INPAT_POS | HIV Positive yield at inpatient wards | Tingathe PITC Registers | Adult Male: 4% Adult Female: 4% Pediatric (>1y): 3% NRU: 7% | Adult Male: 6% Adult Female: 4% Pediatric (>1y): 1% NRU: 6% | Adult Male: 5% Adult Female: 3% Pediatric (>1y): 3% NRU: 7% | Adult Male: 5% Adult Female: 4% Pediatric (>1y): 1% NRU: 1% |
| OUT_COV | Testing coverage at outpatient departments (OTP, SFP, STI, FP) | MOH departmental registers | STI: 92% OTP: 92% SFP: 92% FP: 93% | STI: 92% OTP: 93% SFP: 94% FP: 94% | STI: 91% OTP: 93% SFP: 94% FP: 94% | STI: 93% OTP: 95% SFP: 93% FP: 96% |
| OUT_PREV | HIV Prevalence at outpatient departments (OTP, SFP, STI, FP) | MOH departmental registers | STI: 17% OTP: 7% SFP: 4% FP: 7% | STI: 4% OTP: 7% SFP: 3% FP: 7% | STI: 4% OTP: 8% SFP: 5% FP: 8% | STI: 19% OTP: 9% SFP: 3% FP: 7% |
| HTS_FRS | Number of clients tested with an FRS slip | MOH HTS register <i>Acceleration sites only</i> | 2869 | 2,347 | 2,428 | 3,461 |
| HTS_FRS_POS | Number of clients newly tested positive who came with an FRS slip | MOH HTS register <i>Acceleration sites only</i> | 276 (9.6% yield) | 263 (11.2% yield) | 300 (12.4% yield) | 281(8.1% yield) |
| INDEX_SCR | Number of Clients Screened who have at least one untested contact | Tingathe Index Register | 2147 | 3787 | 2842 | 6,785 |
| ART_REF | Number of clients referred for ART | MOH ART Referral register | 6813* (85% started on ART within the month). 86% linkage for men, 84% linkage for women. | 7,556 | 7,338 | 7,006 |
| VL_HIGH | Number of clients with | MOH VL register | 5123 (out of 29,069 total) | 2942 (out of 21,974 total) | 90% suppression | 89% suppression |

| Indicator | Description | Data Source | Quarter one results | Quarter two results | Quarter three results | Quarter four results |
|-----------|-----------------|-------------|-------------------------------------|-------------------------------------|-----------------------|--|
| | high Viral Load | | samples returned (82% suppression)) | samples returned (87% suppression)) | | (14,020 high results out of 124,774 total samples in the year) |